985

LD C
NEWARK PUBLIC LIBRARY

1985 Annual Supplement

Health Care Financing Review

20 Years of Medicare and Medicaid

Symposium Contributors:

Lonnie R. Bristow, M.D.
Michael D. Bromberg, Esq.
Senator Dave Durenberger
Karen M. Ignagni
Barbara D. Matula
J. Alexander McMahon
Vita R. Ostrander
Uwe E. Reinhardt, Ph.D.
Congressman Dan Rostenkowski
James H. Sammons, M.D.
Bernard R. Tresnowski
Karen Williams

with legislative background
by Wilbur D. Mills and Wilbur J. Cohen

Also, an overview report on the two programs:
covered populations, use of benefits, and expenditures

Health Care Financing Administration

HE 22.18:

Health Care Financing Review

U.S. Department of Health and Human Services
Margaret M. Heckler, Secretary

Health Care Financing Administration
C. McClain Haddow, Acting Administrator

Executive Editor
David J. Butler, Acting Director
Office of Research and Demonstrations

Associate Editors
Allen Dobson, Ph.D., Director
Office of Research

Linda K. Demlo, Director
Office of Demonstrations and Evaluations

Managing Editor
Gerri Michael-Dyer, Chief
Publications and
Information Resources

Production Manager
Doris H. Simmons

Senior Editor
Alice L. Young

Copy Editor
Laurel Rabin

Editorial Assistants
Alice I. Foley
Marlene C. Kidd

Promotion Manager
Linda F. Kropman-Cantale

Send articles, correspondence, and news items to:
Managing Editor
Health Care Financing Review
Rm 1-A-9 Oak Meadows Bldg.
6325 Security Blvd.
Baltimore, Md. 21207

Subscription Information
To subscribe to the *Health Care Financing Review*, send check or money order—$4.25 per single issue, domestic; $5.31 foreign: $18.00 per year, domestic; $22.50 foreign—to Superintendent of Documents, U.S. Government Printing Office, Washington D.C. 20402. All correspondence about paid subscriptions (for example, change of address or failure to receive an issue) should also be addressed to the Superintendent of Documents.

The *Health Care Financing Review* is indexed in the *Index to U. S. Government Periodicals, Abstracts of Health Care Management Studies, Excerpta Medica, MEDOC*, and the *Hospital Literature Index*.

Statements contained in *Review* articles are solely those of the authors and do not express any official opinion or endorsement by the Health Care Financing Administration.

Health Care Financing Review is published quarterly by the Health Care Financing Administration's Office of Research and Demonstrations (ORD). The Office of the Actuary (OACT) contributes the featured statistical report in each issue. The Bureau of Data Management and Strategy (BDMS) provides the health care financing trends data that highlight aspects of the Medicare program.

The Health Care Financing Administration (HCFA) was established to combine health financing and quality assurance programs within a single agency. HCFA is responsible for the Medicare program, Federal participation in the Medicaid program, and a variety of other health care quality assurance programs.

The mission of the Health Care Financing Administration is to promote the timely delivery of appropriate, quality health care to its beneficiaries—approximately 50 million of the Nation's aged, disabled, and poor. The agency must also ensure that program beneficiaries are aware of the services for which they are eligible, that those services are accessible and of high quality, and that agency policies and actions promote efficiency and quality within the total health care delivery system.

The Office of Research and Demonstrations conducts studies and projects that demonstrate and evaluate optional reimbursement, coverage, eligibility, and management alternatives to the present Federal programs. In addition, ORD examines the impact of HCFA programs on health care status, utilization, and expenditures, as well as their effect on beneficiary access to services, health care providers, and the health care industry.

The Office of the Actuary directs the actuarial program for HCFA and monitors national health care expenditures and prices. OACT also provides analyses on the costs of current HCFA programs and the impact of possible legislative or administrative changes in the programs.

The Bureau of Data Management and Strategy operates HCFA's statistical data systems and maintains the national Medicare statistical files. BDMS also serves as the focal point within the agency for information systems policy, planning, and data standards development.

Health Care Financing Review

1985 Annual Supplement

U.S. Department of Health and Human Services
Health Care Financing Administration
Office of Research and Demonstrations
Baltimore, Maryland
December 1985

Editorial policy

The editorial policy of the *Health Care Financing Review* is comparable to that of other professional journals. The Executive Editor decides which of the submitted articles are relevant to the health care financing field in general and to the Health Care Financing Administration in particular. *Review* readership is encouraged to submit appropriate manuscripts for consideration.

The Associate Editors manage the peer review process and are responsible for the professional quality of *Review* articles. All articles of interest are sent to a panel of peers with expertise in the subject areas addressed, and they review articles in terms of substance, originality, validity, clarity, and significance. Their comments, along with those of the Associate Editors, are transmitted to the authors. Authors whose manuscripts are accepted for publication may be asked to make revisions based on these critiques.

The Managing Editor has responsibility for the publications standards of the *Review* and the editorial quality of the articles published, and the editorial staff work with authors on preparing their articles for publication.

The *Review* is published on a quarterly basis and each issue represents a balance between contributors from inside and outside the government. We welcome potential articles from readers. Papers to be considered for publication should discuss health care research, policy, the development of a particular project or demonstration, or other subjects of interest to the *Review* audience. This audience comprises Congress, Federal, and State and local officials, as well as health care providers, insurers, planners, researchers, and economists.

Preface

The *Health Care Financing Review* is published quarterly by the Health Care Financing Administration (HCFA). It features statistical reports and research articles on major issues relating to the delivery and financing of health care services. At the end of each year, the *Review* also publishes a supplement which focuses on a special topic of interest.

In the fall of 1984, HCFA decided to devote the 1985 Annual Supplement to the 20th anniversary of Medicare and Medicaid. Because these programs are perceived to be at a major "crossroads," as they mature and enter an era when many basic assumptions are being questioned, we wanted the *Review* to provide a forum for an assessment of the programs after two decades of operation. To focus on program issues, it was decided to hold a written "Symposium on Medicare and Medicaid, 1965-1985," and seek opinions from leaders and experts in the field who represented a broad spectrum of knowledge and opinion.

We formulated questions on four broad issues for discussion: the impact of Medicare and Medicaid on the beneficiaries, the providers of services, and the government, and possible future directions for the programs. The Administrator of HCFA sent letters of invitation to 18 distinguished experts, representing a range of outlooks and opinions, requesting them to participate in the Symposium. Each invitee was sent the same set of questions and asked to consider these issues and prepare a written response. The questions are reprinted for our readers, preceding the Symposium responses.

In addition, two legendary figures in the history of the Medicare and Medicaid legislation—Wilbur D. Mills, Chairman of the House Committee on Ways and Means, and Wilbur J. Cohen, who was involved for nearly 20 years in the development of the legislation—were solicited to prepare a special paper on the legislative background of the Medicare and Medicaid programs.

This issue of the *Review* also features a background article on Medicare and Medicaid. It provides a broad overview of program enrollees, use of services, and program expenditures, 1965-1985.

Of the 18 people invited to participate, 12 sent in papers in response to the Symposium questions. Mr. Mills and Mr. Cohen also prepared articles especially for this issue. The *Review* wishes to express appreciation to all our contributors to this supplement marking the 20th anniversary of Medicare and Medicaid.

David J. Butler
Executive Editor

NEWARK PUBLIC LIBRARY
JAN 9 1986
U. S. GOVT. PUBS.
DEPOSITORY 376

blank page

READEX FICHE

best copy available

Foreword

As Administrator of the Health Care Financing Administration (HCFA) from 1981 to August 1985, I am most pleased that the 1985 Annual Supplement to the *Health Care Financing Review* is devoted to reflections on Medicare and Medicaid. From their very beginning, these programs impacted on the Nation's entire health care system. Because of their broad social importance and because they affect the lives and well-being of so many in our Nation, it is vital for us to follow the wisdom of George Santayana who cautioned us to "remember the past." In essence, this special issue of the *Review* seeks to look back in order to understand the origins of these programs and to discover what we can learn from their experience to date.

In 1985, as we consider the opportunities and options for the future, it is important to remember that the enactment of Medicare in 1965 represented the Nation's response to the plight of people 65 years of age or over—the age group with the highest incidence of illness and disability, the lowest income, and the least adequate private health insurance coverage. Medicaid was enacted at the same time to provide health care coverage for the poor.

We are grateful that the Honorable Wilbur D. Mills and Wilbur J. Cohen have provided articles that present their perspectives on the legislative background of these landmark programs. Clearly, a multitude of factors were involved in the legislative decisionmaking back in 1965, including the health care needs of the aged and the poor, their economic status, and the strengths and weaknesses in the public and private sectors of our society at that time to meet those needs.

Creation of Medicare and Medicaid gave the Federal Government a major role in financing health care. Few would have anticipated their speedy and profound impact on the health care system. In the summer of 1976, on their 10th anniversary of operation, *Public Health Reports* featured a series of articles by leading experts, analyzing Medicaid and Medicare. These programs were appraised, on balance, as having had a considerable impact on the aged in lessening their anxiety about financial ruin from health care needs and on the poor in providing needed access to health care services. The overwhelming public concern, however, was the persistent escalation in health care costs, and the open-ended, uncontrolled government outlays.

Viewed from the perspective of 1976, the second decade of these programs is marked as a period of continuing impact on the beneficiaries and the health care system, as well as an era of innovation and change. In March 1977, 2 years into the second decade, the Health Care Financing Administration was created to consolidate and improve the administration of the two programs. The second decade was also marked, in Medicaid, by the introduction of considerably more program flexibility and, in Medicare, by the introduction of the hospital prospective payment system (PPS). By controlling the annual escalation in program outlays for hospital care, PPS has improved considerably the climate and outlook for the future. This is most clearly evidenced by the fact that the Medicare hospital insurance trust fund is now thought to be financially sound until the turn of the century, when not long ago the prognosis was considerably less optimistic. Enhanced competition among providers, including the development of health maintenance organizations and competitive medical plans, has also provided opportunities for the delivery of high-quality health care services. More needs to be done, however, in terms of the fundamental restructuring of the way health care is delivered and paid for under these programs to strengthen their cost efficiency and effectiveness and to preserve and improve quality care.

Today, 20 years after the legislation, Medicare and Medicaid together serve approximately 50 million out of the nearly 240 million citizens in our Nation. Expenditures for the Medicare and Medicaid populations totaled approximately $100 billion or about 30 percent of the Nation's total health care bill. The magnitude of the programs, in the number of citizens affected and the billions of dollars expended, means that their effectiveness and efficiency is of utmost concern to all of us.

We were honored that so many distinguished persons with a diversity of experience and opinion responded to our call to take part in a Symposium on Medicare and Medicaid. The sharing of knowledge and ideas by these experts, policymakers, and scholars allows a nonpartisan exchange of ideas and represents an important public service by our contributors. I am hopeful that this 20th anniversary assessment will help us gain a better perspective and understanding of the Medicare and Medicaid programs and will help guide their future directions.

Carolyne K. Davis, Ph.D.

Contents

Legislative Background

Building a better safety net
by Wilbur D. Mills

Reflections on the enactment of Medicare and Medicaid
by Wilbur J. Cohen

Overview

Twenty years of Medicare and Medicaid: Covered populations, use of benefits, and program expenditures
by Marian Gornick, Jay N. Greenberg, Ph.D., Paul W. Eggers, Ph.D., and Allen Dobson, Ph.D.

Symposium Contributors

Lonnie R. Bristow, M.D.

Michael D. Bromberg, Esq.

Senator Dave Durenberger

Karen M. Ignagni

Barbara D. Matula

J. Alexander McMahon

Vita R. Ostrander

Uwe E. Reinhardt, Ph.D.

Congressman Dan Rostenkowski

James H. Sammons, M.D.

Bernard R. Tresnowski

Karen Williams

Building a better safety net

by Wilbur D. Mills

Wilbur D. Mills became a member of the Committee on Ways and Means in October 1942, and was elected Chairman of the Committee in January 1958. At the time of his election, Mr. Mills was the youngest Chairman in the history of the Committee. He served as Chairman of the Committee from 1958 until December 1974, establishing the longest tenure of continuous service as Chairman of this Committee. Mr. Mills retired from Congress in 1977 and is presently counsel to the law firm of Shea and Gould in the Washington D.C. office.

I am indeed proud of having had the opportunity to bring the Medicare and Medicaid programs into existence in 1965 as Chairman of the House Committee on Ways and Means.

As a member of the Committee, I had participated since 1949 in numerous discussions with Wilbur J. Cohen on trying to solve, through social insurance, some of the major problems arising from disability and sickness costs. Over the next 19 years, we worked together cooperatively to find acceptable ways and means to provide legislative vehicles to deal with these complex problems.

When I came to the Congress in 1939, I was already a firm believer in the need for, and the fundamental national wisdom of, the social security system. I supported the Survivors' Insurance Amendments of 1939 and the Disability Insurance Amendments of 1956. I became familiar with the actuarial assumptions of the program, working with Robert J. Myers, and the administrative structure of the program, through close association with Robert M. Ball and previous Commissioners of Social Security, such as Arthur J. Altmeyer and Charles I. Schottland. I was convinced that the objective of social security—to provide a basic floor of protection—was sound and essential if we were to prevent millions of people from having to seek welfare or to be forced to live with incomes below the poverty line.

In 1950, we began, on a modest basis, to authorize the idea of "vendor payments" for medical care to needy public assistance recipients, an idea that Wilbur J. Cohen brought to our attention as a means of getting some experience in the medical services area. We expanded and modified this idea in 1954 and 1956 at the same time we were strengthening the social security program. In 1957, 1959, and 1960, we held hearings and discussions on the Forand Medicare bill. In 1960, we also held extensive hearings on a nationwide medical assistance proposal advocated by President Dwight D. Eisenhower and Arthur S. Flemming, the Secretary of Health, Education, and Welfare. Out of these deliberations came a revised proposal for Federal grants to the States to improve medical assistance to the needy aged. In the Senate, the House version was revised with the aid of Senator Robert S. Kerr of Oklahoma and Wilbur J. Cohen, and it became the Kerr-Mills legislation of 1960, which I sponsored as a stopgap measure for the needy until we could obtain agreement on any further legislation.

The Kerr-Mills legislation became a controversial measure in the early 1960's because it only dealt with the needy aged, and I could see that something more would have to be adopted eventually. President John F. Kennedy and Vice President Lyndon B. Johnson were pressing strongly for a Medicare-type insurance program for all the aged. But I also could see that such a legislative measure did not have the necessary votes at that time in the Committee on Ways and Means or in the House of Representatives. For 4 years (1951-1964), we struggled to find compromises, adjustments, and adaptations that might lead to agreement between the House and Senate. These discussions broke down in the conference on the 1964 social security legislation. I outlined some of the problems we had to resolve in an address I gave on September 28, 1964, which I placed in the *Congressional Record* of October 3, 1964.

With the resounding victory of President Lyndon B. Johnson in the 1964 campaign, it was inevitable that some Medicare program would be adopted in 1965. I proceeded promptly to try to develop a legislative package that could be passed.

It became increasingly clear to me, however, as I studied the programs and consulted with many interested groups, that a Medicare hospital insurance program for the aged alone was not sufficient to meet the many medical problems of the aged, blind, and disabled or the mothers and children receiving aid for dependent children. With Wilbur Cohen's help, we developed what eventually became Medicaid (Title XIX) and Medicare. Then, with the support of John W. Byrnes, the ranking minority member on the Committee, we added voluntary coverage of physicians' services in what became Part B or supplementary medical insurance (SMI). That three-part program, enacted in 1965, has been an important and essential part of our national safety net for the past 20 years, along with social security and the Supplemental Security Income program enacted in 1972.

In the same 1965 legislation, we improved the social security program (old age survivors and disability insurance) as well as the public assistance programs. In this year of the 30th anniversary of the original Social Security Act of 1935, and the 20th anniversary of Medicare and Medicaid, I am proud of the part I played in helping to initiate, preserve, and improve these safety-net provisions.

I do not believe these programs are perfect. They can and will be expanded and improved as we gain more experience in implementing them. But I believe they are here to stay. They are now part of the American way of life.

blank page

Reflections on the enactment of Medicare and Medicaid

by Wilbur J. Cohen

Wilbur J. Cohen has been a Professor at the Lyndon B. Johnson School of Public Affairs at the University of Texas at Austin since 1980. He served as Chairman of President John F. Kennedy's Task Force on Health and Social Security (1960-61). Between 1961 and 1968, he served as Assistant Secretary, Under Secretary, and Secretary of the Department of Health, Education, and Welfare, the only person ever to hold all three positions. He was one of the principal architects of Medicare and Medicaid and had primary responsibility for piloting the legislation through Congress, and for its initial implementation.

Introduction

To place my present-day comments in historical perspective, it must be appreciated that I spent 15 significant years of my life (1950-65) helping to design the basic framework and pilot through the Congress[1] what became known as Medicare and Medicaid. I spent an additional 3½ years (1965-68) helping to make the initial decisions relating to the implementation and administration of both programs. Understandably, I have a personal and even an emotional concern about these programs for which I, and many of my associates, expended so much time and energy.

It is difficult for many younger people today to realize how harsh many of the criticisms and arguments against these health proposals were.[2] For instance, the Scripps-Howard newspapers on June 20, 1966, had an article with the headline "AMA Sees Wilbur Cohen as 'Enemy No. One.' " At the 1966 American Medical Association House of Delegates, resolutions were introduced by physicians from Florida and Louisiana asking "President Johnson to launch an investigation of Mr. Cohen, culminated by a swift booting out of office." Now 20 years later, despite the various criticisms, problems, and proposals, there is no substantial or responsible individual or group that I know of that advocates the total repeal of either of these once-controversial programs. But there are various proposals for restricting, restructuring, or even expanding them.

For 9 years (1957-65), Medicare and Medicaid were highly controversial issues. To understand some of the legislative provisions that were incorporated into these programs, it is necessary to recall the ethos of the 1950's and 1960's when some of the fundamental decisions were made. There was only a limited amount of experience with large-scale, nationwide, health reimbursement programs. There was a good deal of rhetoric and little empirical information. There was an extensive outpouring of ideology and a limited amount of research. These facts had a significant bearing on the outcomes.

The beginnings

In the following discussion, I will selectively recall and examine some provisions in Medicare and Medicaid that have not been previously discussed, and for which I participated in the decisionmaking process. I chose those provisions or policies in the two laws about which some ambiguity, misunderstanding, or misconception still remains. I will not discuss those aspects of the development of the legislation that are recorded in existing publications (Harris, 1966; David, 1985; Marmor, 1970; Myers, 1970; Corning, 1969; and Campion, 1984).

The full story of the development and history of Medicaid prior to its enactment has not yet been told, although some discussion is provided in Stevens and Stevens (1974) as well as some of the references previously cited that deal with the legislation. The inclusion of Medicaid in the 1965 law evolved when Mr. Wilbur Mills asked me what his answer should be to the inevitable question he thought he would be asked during the legislative debate: "Isn't Medicare an 'entering wedge' to a broader program of nationwide 'compulsory' insurance coverage of everyone?" I suggested that if he included some plan to cover the key groups of poor people, he would have a possible answer to this criticism. Medicaid evolved from this problem and discussion. I developed most of the provisions by expanding the plan requirements in the Kerr-Mills bill of 1960, taking into account the views of State welfare directors. Most Federal and State public health officials had no interest in administering such a program because of the fear that it would involve them in disputes with physicians.

Although I had been a strong advocate of a comprehensive and universal nationwide health insurance plan since 1940,[3] I was conscious of the monumental administrative and management problems involved in such a large undertaking. My professors and mentors had stressed administrative competence in social legislation. The merits of the incremental approach to implementing the social security system, which began in 1938 under the leadership of Arthur J. Altmeyer, was always in the forefront of my mind. Underlying this approach was the acceptance of the desirability of learning by doing—a pragmatic approach of trial and error—and of resolving problems arising from the unintended consequences of legislative action that affected human and institutional behavior.

---

[1] An extensive legislative history of the 1965 Act is provided by Cohen and Ball (1965) and Cohen and Peerboom (1966).

[2] Some of the pamplets, headlines, and various arguments are included in Campion (1984) and Harris (1966). Detailed commentary on the legislative struggle is presented in a dozen oral histories, Columbia University Library, New York City, summarized in Corning (1969).

[3] I assisted in the drafting of the Wagner-Murray-Dingell comprehensive national health insurance bill of 1943, and the Truman health message of 1945.

As questions arose in 1949, both in the Congress and in the marketplace, on innumerable economic, medical, and political issues on public and private health plan proposals, I began to wonder whether some more limited or experimental public plans might provide the Social Security Administration with needed administrative experience. We might learn of acceptable as well as unacceptable responses to various problems, such as accreditation of hospitals, reimbursement policies, Federal-State roles, and the participation of physicians and other providers as well as prepaid group practice plans. In 1950, I drew up a strategy that involved congressional authorization for "vendor payments" for medical assistance to the aged, blind, and disabled (enacted in the Social Security Amendments of 1950, 1956, and 1960); medical determination for a disability "freeze" (1952 and 1954),[4] disability insurance benefits (1956), and Medicare and Medicaid (1965). This sequence of events brought the Federal Government into the mainstream of health policy administration. I felt we had to get our feet wet in working with hospitals and physicians to discover ways and means of resolving problems, rather than debating ideology in a vacuum.[5]

It is frequently overlooked that the American Medical Association (AMA) originally opposed early versions of even a limited Medicaid proposal. On April 24, 1956, the AMA informed Congress:

> "The American Medical Association is vigorously and firmly opposed to this step.
>
> "First, we see no need for the establishment of medical care as a fifth and separate category of Federal aid in public assistance programs. Pooling arrangements now available to the States under the existing program can accomplish more flexibly and less dangerously all the new proposals seek.
>
> "Second, such a new program would burden the community with regulations and restrictions inconsistent with local problems, local laws, or local customs. As an example, amendments to the aid-to-blind program under the Social Security Act have granted to optometrists since 1952 the privilege of diagnosing pathological conditions of the eye. This privilege, until 1952, had been uniformly denied to them by state licensure laws.
>
> "Third, this section is totally inconsistent with the philosophy heretofore underlying Federal participation in public assistance programs. This philosophy, as expressed in the other titles of the pending bills, presupposes that Federal participation in such programs is a temporary expedient, necessary only because the old age and survivors benefits are not yet sufficiently matured to furnish the basic protection required. As the old age and survivors benefits mature, it has always been supposed that Federal participation in public assistance would be reduced. The medical provisions of the pending bills represent an expansion in Federal participation, contrary to this established policy.
>
> "Fourth, we cannot escape the conclusion that injection of medical care as a separately matched category of expenditure under public assistance is only a forerunner to the injection of medical care as a categorical benefit under old age and survivors insurance. You are aware of the overwhelming rejection by both the American people and the medical profession of this philosophy. As physicians, we must continue to oppose programs which, in the guise of improving medical care, will lead to the destruction of the system which has produced the best medical care ever enjoyed by any people.
>
> "In summary, the American Medical Association is vigorously opposed to the proposed changes in the medical care provisions of the public assistance sections of the Social Security Act. We are opposed to those changes because they are needless, wasteful, dangerous, and contrary to the established policy of gradual Federal withdrawal from local public assistance programs." (U.S. Congress, 1956)[6]

The primary source of my early and long association with Medicare is that I suggested it to Oscar Ewing in 1950 as a fall-back position after the defeat of the Truman national health insurance proposal and the Wagner-Murray-Dingell bill to carry it out.[7]

Then, later in 1957, I helped to draw up Senator John F. Kennedy's program for the aged, which included Medicare. This became the basis for the Kennedy-Johnson Administration support for

---

[4] The disability freeze provided that when a person became disabled, his or her social security earnings record would be frozen and the period of disability omitted from the computation of the old age or death benefit. It is comparable to a waiver of premiums in private life insurance policies, which provides for a paid-up life insurance policy at the time of disablement without payment of any future premiums. The disability freeze was first enacted in the Social Security Amendments of 1952, but it never went into effect. I had suggested this unusual compromise provision to Representative Wilbur D. Mills (Truman, 1952). An operative provision was enacted in the Social Security Amendments of 1954.

[5] Although the Maternal and Child Health and Crippled Childrens' Services legislation had been enacted in 1935 and provided reimbursement policies for hospitals and physicians (which were known and available), these programs did not become a significant factor in reimbursement discussions in the formulation of Medicare and Medicaid. A careful study of public sector reimbursement policies and history before 1965 is needed. No responsible person that I know of suggested a practical and acceptable alternative to reasonable costs or reasonable charges during the 1940-65 discussions.

[6] These bills were introduced at the request of the Eisenhower Administration as Administration proposals. The AMA has been supportive of the principle of Federal financial assistance for maternal and child health and crippled childrens' services since 1935 and to the elderly poor since the Kerr-Mills bill of 1960. The 1956 position remains unexplained even to this late date.

[7] If any should get the credit for the earliest suggestions in 1937 of what eventually became called Medicare, it was Dr. Thomas Parran, the Surgeon General of the Public Health Service (Corning, 1969). From a practical point of view, the idea came from Merrill G. Murray, Assistant Director of the Bureau of Old Age and Survivors Insurance in two 1944 memos. (Copies of these memos are in my possession, along with numerous other documents on Medicare and Medicaid).

Medicare in 1960 and between 1961 and 1965.

In 1960, President-elect Kennedy appointed me Chairman of a Task Force on Health and Social Security, which recommended Medicare and other health proposals (Cohen, 1961). Shortly thereafter, he nominated me Assistant Secretary of Health, Education, and Welfare for Legislation; this involved assigning me primary responsibility for both the formulation and design of the Medicare program and for piloting the legislation through Congress.

The ideological and political issues between 1960 and 1965 were so dominating that they precluded consideration of issues such as reimbursement alternatives and efficiency options. However, utilization review and health maintenance organization (HMO) relationships did receive attention. But it was deductibles and the duration of hospital benefits that received primary political attention and involved controversial alternatives.

Several differences about policy and strategy arose while Congress considered the legislation during the Kennedy Administration (1961-63).

Ivan Nestingen, the Under Secretary of the Department of HEW, had been the mayor of Madison and was a friend of Kenneth O'Donnell, the Appointment Secretary to President Kennedy. He persuaded O'Donnell and several others in the White House to augment grass roots pressure on Wilbur D. Mills, Chairman of the House Committee on Ways and Means, to report out the Medicare bill. Nestingen believed I was working too closely with Mills, but not pressuring him politically. He was correct in his observation. I felt we just did not have the votes in 1961, 1962, or 1963 in the House Committee and had to rely on an increase in congressional supporters in the 1964 election. Nestingen tried to put political pressure on Mills, but Mills told the White House he would not deal with Nestingen, and Nestingen's apparatus fell apart. However, it was a strain on me as tensions rose between Nestingen's friends and mine. Nestingen eventually resigned after Lyndon B. Johnson became President.

The second problem arose out of the strong opposition of Senator Pat M. McNamara (D., Michigan) to any deductible on hospital insurance. Most other Administration supporters wanted a modest deductible with a longer duration of hospital benefits at the same cost. To placate McNamara, I suggested to Theodore Sorensen, President Kennedy's assistant, that we revise the Administration bill to provide a uniform duration with no deductible, but with a provision whereby individuals could elect once a year to change to a longer duration with a deductible. Sorensen thought this was a reasonable way out of our conflict with McNamara and cleared the idea with President Kennedy. When Robert M. Ball, the Commissioner of Social Security, heard about my suggestion from me, he said it was administratively unworkable. He convinced HEW Secretary Anthony J. Celebreeze to give him an opportunity to see President Kennedy on the matter. Celebreeze, Ball, and I had a conference with Kennedy and Sorensen in the Oval Office. When Ball said the proposal would result in administrative chaos, President Kennedy replied with a smile, "Well, then, let's have a little chaos." The Congress, however, was strong for a deductible and, as I predicted, my idea for an alternative never got to first base.

The third big issue was the use of Blue Cross plans as fiscal intermediaries in the administration of the hospital insurance program. Ball felt the Social Security Administration could do a more effective, efficient, and responsible job than the many diverse private plans. But political leaders were worried about whether the program could be satisfactorily administered. So the use of fiscal intermediaries was inevitable.

President Johnson was concerned over the possibility of failure of an aged person to gain access to a hospital bed because of an abnormal number of backed-up admissions for elective surgery on the first day or two of the program. He authorized me in 1966 to use Federal military and veterans' hospitals for emergency cases. Special arrangements were established under the supervision of the Assistant Secretary for Health to handle such emergencies. The special arrangements proved to be unnecessary.

Later, I persuaded President Johnson to set up a mechanism in 1968 to review and consider a coordinated policy for all federally financed hospital programs. The President announced the policy, but it never went into effect because of the opposition of veterans' groups and their congressional supporters. This early attempt at a cost-constraint approach on a limited basis fell flat on its face under the vested interest of veterans' organizations.

Legislative process: 1964-65

The influential Wilbur J. Mills was a strong supporter of the contributory social security system. He was both a fiscal conservative and a conscientious and cautious legislator. Prior to 1965, he was not a sponsor of the Medicare proposal. He was always careful, however, in articulating his opposition to the Medicare legislation to allow himself room to adapt to future possibilities. He would commit himself to opposition, specifically to the "King-Anderson" bill, but he was careful not to oppose outright the principle of health insurance for all the aged, although he had doubts about doing so through the social security system. He would identify problems, issues, and questions, but he was continually searching for solutions to the difficulties he saw as political objections to enactment of a law.

With the decisive victory of Lyndon B. Johnson in the 1964 election campaign, Chairman Mills immediately realized he should support some kind of measure along the lines of the Medicare proposal advocated by the Johnson Administration. Johnson was keenly aware of Mills' legislative skill and his technical knowledge of social security legislation. He appreciated the need to give Mr. Mills some time and elbow room. President Johnson did not try to second guess Mills as to how to get a bill reported out by the Committee. In addition, President Johnson gave me no specific instructions as to how to deal with Chairman Mills on substantive or procedural issues. Johnson's legislative relationships with Mills were handled primarily by Larry O'Brien and Henry Hall Wilson directly from the White House. Mr. Mills went about holding public hearings in 1965 and private consultations in his usual businesslike and thorough manner. Although he consulted frequently with me, he also consulted with Robert M. Ball, Robert J. Myers, and many of his staff and other outside people.

With the Johnson election victory, the AMA finally and belatedly decided to sponsor a counterproposal to Medicare. So did some of the Republican members of the Committee. These two proposals had one element in common—they were broader than hospital care and provided for covering physicians' services. The proposals were also based on the principle that they were not related to social security or the contributory and compulsory payroll tax basis, which was a continual point of opposition by the AMA and the Republican supporters.

At the time (February 1965), there were three options being proposed: (1) a program that would be income-tested rather than "insurance", (2) a program divorced from the social security system, and (3) a voluntary program.

When the public hearings in 1965 were concluded, executive discussions began on January 27, 1965, to hammer out the specific details of a bill which, inevitably, would be a Mills bill rather than a King-Anderson bill. Day after day we would meander through various technicalities. In off moments, when the Committee was in recess, a staff member of the senior Republican Committee member, John W. Byrnes, would ask me why I did not support some broader coverage proposal such as the one available to Federal employees through commercial insurance (the Aetna plan). I knew I had no authority to support a commercial-insurance-type proposal. Besides, the main supporters of Medicare were opposed to such an indemnity plan. Consequently, I never brought the idea to the attention of the White House. The private relationship, voluntary election, and broader coverage were tied together by those advocating a counterproposal.

I have no specific information on how Mills came to his position to include physicians' services. He did not give any advance indication of his willingness to do so. Although Mills was not an impulsive decisionmaker who would do something monumental on the spur of the moment, he was insightful and sensitive. He instinctively realized that this was a way to capture the support of his Republican colleagues. Mills wanted his colleague John Byrnes and some Republicans to support the legislation; he worked hard at trying to find a way to bring Byrnes and some, if not all, of the Republicans or the Committee to a consensus. This was Mills' general way of working on tax and other major bills.

One afternoon, as we went through questions and answers as usual, Byrnes again raised his broader proposal idea. I was the primary Administration representative, seated in the center of a group of Departmental experts at a long table below the great, raised horseshoe table at which sat all the members of the Committee. Without any advance notice, Mills asked me why we could not put together a plan that included the Administration's Medicare hospital plan with a broader voluntary plan covering physician and other services. I answered that it was possible. I had no specific authority from anyone to underwrite such a proposal, but I had enough common sense not to dismiss it out of hand. Then we wrote up the new proposal, virtually overnight.

Mills did not spell out any specifics to me. Rather, he urged prompt action on a draft of such a proposal. I asked for a little more time to complete such a major undertaking. Mills said no, he wanted it the next day. I felt he sensed that he had caught the critics off guard, and he did not want them to have time to regroup. He was like a general who saw he could rout his opposition and follow them as they retreated. Mills recessed the Committee in his eagerness to forge ahead under the momentum that had been created. It was a brillant tour de force. And it provided me with an opportunity to quietly steal away to touch base with my principals. I left Bob Ball with the responsibility of having his staff draft up the specifications that eventually became Part B of the Medicare program. Larry Tilson, of the staff of the Congressional Legislative Counsel, had primary responsibility for drafting the legislation, in cooperation with Ed Craft and Sidney Saperstein of the General Counsel's office of HEW, and Irwin Wolkstein and Alvin David of the Social Security Administration.

I went back to the office and, fortunately, found President Johnson in the nearby office occupied by John Gardner, the Secretary of HEW. I barged in and briefly told the President what had occurred. I told him that it would probably cost $500 million or so in general revenues the first year. The President did not bat an eye. He accepted the situation calmly, which I took for approval and clearance. It was a strange and unique way in which to make a major policy decision. There was no policy clearance with others in the Department or in the Budget Bureau or White House.[8] Mills had scored a coup. Johnson immediately realized it. I was the intermediary for a major expansion of our proposal without any intervening review of the details of the proposal as developed by the staff. In this case, the Federal Government was moving into a major area of medical care with practically no review of alternatives, options, trade-offs, or costs. Physicians and the AMA were also caught off base as the ball game quickened and the players sensed something radically new had affected the ball game. I raised no basic questions either within the Administration or in the Committee. It was like the ball game was in the ninth inning, with two outs, two strikes, and three balls on the batter. One more pitch would or could decide not only the game, but the World Series.

---

[8] As a matter of fact, I never discussed any policy elements in any detail with Douglas Cater or Joseph Califano, the President's assistants during the Johnson Administration. My dealings on any substantive matters were exclusively with Larry O'Brien of the legislative staff, and his assistants, Harry Hall Wilson and Mike Manatos. In the Kennedy Administration, however, I discussed substantive issues with Theodore Sorensen, the President's assistant.

For me, at the moment, the big question was not on the method of reimbursement to physicians but rather on the "voluntary" nature of Part B. That was a sharp divergence from a compulsory social insurance philosophy. But I felt that Part B was a big step forward, even if we did not have specific administrative plans on how to implement it.

Moreover, no one on the Committee raised any questions about the radically new principal of using Federal general revenues—equal to 50 percent of the cost of the plan. We felt that such a subsidy would be necessary to make a voluntary plan accepted by low-income retired people.

As I recall it, no major question arose in the House, Senate, or Administration on this unexpected addition of Part B, except for the issue of how to reimburse specialists like radiologists, pathologists, and anesthesiologists. We had always assumed they would be reimbursed from the hospital insurance program (Part A).

My view, and that of my colleagues, had been that these three specialties were traditionally hospital-based physicians who should be reimbursed under Part A as part of the hospital reimbursement and not in Part B as independent entrepreneurs.

My first glimmer of the problem, which was soon to emerge as the key controversial issue affecting Parts A and B, was when Mills asked me to meet with him in his private office off the floor of the House of Representatives. When I entered the office, I found Mills with a radiologist from Little Rock, Arkansas, who was quietly telling Mills he was not an employee of the hospital and did not want to be. He was making the same basic argument that I had heard over the years by newspaper boys, truck drivers, and salesmen, that they were "independent contractors". Mills must have given instructions to the draftsmen who were under his control as to how to change the bill. Mills was adamant despite our pleas to keep the specialists in Part A. We planned to ask the Senate to reverse the decision. However, when the bill was about to come to the full House of Representatives for consideration, President Johnson telephoned me and instructed me to get this particular action reversed because of the additional costs involved. He may have also telephoned Speaker John McCormack on this matter. I have no information as to whether he had discussed it with Chairman Mills or not.

I went up immediately to Speaker McCormack's office in the Capitol. There were at least six or seven of the key congressional leaders seated with him. Mr. Mills was absolutely opposed to changing his decision. He would not come into the meeting. It was a tense situation. Speaker McCormack was not persuasive with Mills, but felt he should report developments to the President. He telephoned the President and, when he finally reached the President, he said, "Wilbur Cohen will explain the situation to you." I had been quitetly seated, waiting for the Speaker to handle this matter. When I answered the phone, the President was clearly unhappy about developments; he was annoyed at the interruption because of the negative response to his demands.

During the next few weeks in the Senate and the Conference Committee, Robert Ball and I tried to work out a solution to this problem. At one time, we though Mr. Mills and Representative Hale Boggs had agreed to a compromise that we had worked out, but in the end Mr. Mills rejected it. That is how radiologists, pathologists, and anesthesiologists came to be included in Part B in the 1965 law. Mr. Mills demonstrated he could withstand pressure from the President, the Speaker, and his experts. It underscores the importance of having had Mills on your side in every aspect of the legislative process, and the significance of grass roots influence on legislation.

Implementation

The hospital part of Medicare had been in one or another stage of staff discussion since 1942 when the first Federal nationwide hospital insurance bill had been introduced in Congress (Brewster, 1958 and 1962). The many different versions of such legislation had resulted in pinpointing administrative and policy questions and tenatively deciding ways to handle them. The enactment of the disability insurance provisions in the early 1960's helped substantially to assist the staff in working out medical certification policies and forms, developing relationships with physicians and hospitals, and becoming knowledgeable about key participants in the health insurance connection. Responsibility for these disability laws was assigned to Arthur Hess, who thus became the appropriate person to initially head up the Medicare program. Hess did a remarkable job in winning the professional support of physicians and hospitals for the program.

A significant factor in the initial acceptance of physicians and other providers of the policies, forms, and regulations of the Medicare program was the participatory role of the Health Insurance Benefits Advisory Council. Representatives of the American Medical Association, American Hospital Association, the American Federation of Labor-Congress of Industrial Organizations, and other groups had a recognized statutory place to communicate and exchange ideas with the administrators of the program. The importance of this institution during 1965-70 cannot be overemphasized. I personally selected the members of the first Council to be sure there was adequate representation from former critics and supporters of the law.

In addition, I conscientiously carried out the promise I made in the executive session of the House Committee on Ways and Means that private commercial insurance carriers would receive equal consideration with nonprofit organizations as fiscal intermediaries for supplementary medical insurance. This required some persuasion and handholding with the carriers who initially did not believe the Government would do this. I personally assured the private commercial insurance carriers of this policy in a special meeting with them. With Robert Ball, I selected the initial private commerical insurance carriers and other fiscal agents in each of the States and territories to assure an equitable and fair division of responsibilities.

Successful implementation of Medicare required the cooperation of hospitals, physicians, nurses, carriers, intermediaries, and other providers. The primary objective of 1965-67 was to get off to a good start, to avoid any strike, slowdown, or other uncooperative action.

One feature that I build into the legislation was making the effective date July 1, 1966. Respiratory diseases have a low incidence in summer, and elective surgery is at a low ebb immediately before the July 4th holiday period. We needed every day of the approximatley 11 months we had to prepare for putting the law into effect. I think initiating the law during a low-admission period in the summer substantially helped to make the initiation of the program successful.

Reimbursement policy under Medicare and Medicaid

The principle of "reasonable cost" for in-patient hospital services embodied in section 1814(b) and 1861(v) of the Social Security Act was never seriously debated or opposed during the period 1961-65, as far as I can recollect. The provision in the latter subsection that "the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations," was accepted by the Congress and the providers. No one criticized it during the legislative process as a "cost-plus" principle. No one thought of it as a basis for inflationary price or cost rises. It was accepted not only because no other alternative was proposed, but because conventional wisdom at the time accepted reasonable cost as a reasonable principle.

With the acceptance of "reasonable cost" in Title XVIII, I arranged for the inclusion of "reasonable cost" in section 1902(a)(13)(B) of Title XIX but omitted the detail contained in section 1861(v) on the assumption that this would give the Secretary and the States somewhat greater flexibility in a State-by-State administration of Title XIX.[9]

However, I told the members of the House Committee on Ways and Means in executive session in 1965 that payment of comparable reasonable costs in Title XIX would upgrade medical services to the needy and assist in carrying out the "amount, duration, or scope" of equality of treatment requirements in section 1902(a)(10). Chairman Mills accepted this policy enthusiastically on behalf of the Committee (Williamson, 1983; Weeks and Berman, 1985). It was part of the effort to improve and assure quality and equality of treatment of the poor. It must be kept in mind that hospital per diem costs were relatively low during 1935-40 because of low wages paid to nurses and other hospital employees[10] and the absence of fringe benefits (Brewster, 1962). The efforts up through the 1950's were to assure and enhance the quality of hospital service by a more adequate reimbursement of the employees working in the hospital.

Prohibition against Federal interference

> Section 1801 of the Medicare law provides: "Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenture, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person."

Section 1801 was included in the law to offset the criticism made by opponents of the proposal that Federal legislation would give Federal officials the opportunity and the right to interfere in the diagnosis and treatment of the individual. Similar language was also included in bills and laws relating to education. The basic provision was originally included in the Forand bills, in 1957 and 1959 (section 226(d)(5), made more specific and enlarged by the legal staff of the Department of Health, Education, and Welfare when President Kennedy's Administration bill was introduced by Representative Cecil King (D., California) and Senator Clinton Anderson (D., New Mexico) on February 13, 1961. No effort has been made, as far as I know, to amend or repeal this general provision.

---

[9] Section 1902(a)(13)(B) provided for "payment of the reasonable cost (as determined in accordance with standards approved by the Secretary) and included in the plan." The Kerr-Mills Act of 1960 (Public Law 86-778) had used only the term "cost" (section 6(b)). The Eisenhower-Flemming proposal of 1960 (S.3/84) used the phrase "rates of payments for institutional services" and "schedule of fees or rates of payment for other medical services" (section 1602(a)(5)(D)). The authorization for vendor payments in 1950 did not refer to costs.

[10] In 1946, the average annual earnings of full-time general hospital employees was 52 percent of that of a full-time worker in industry; in 1959, it was 60.4 percent; in 1955, it was 66.6 percent; and in 1960, it was 68.9 percent. Total hospital payroll thus assumed an increasingly larger share of hospital expenses.

Evolution of Medicaid

The basic pressure for a Medicaid-type program began to develop in 1942 when Rhode Island wanted to utilize some of the existing public assistance funds under the Social Security Act for direct payments to vendors of medical care. The Social Security Board, however, decided that the law did not permit such a "restricted" payment. This gave rise to proposals within the staff of the Social Security Board to modify the law (Title I, IV, and X) specifically to authorize such "vendor payments."

The Board recommended in 1949 that a new title be added to the law to create a Federal-State comprehensive public welfare program which would include authorization for "medical assistance." The definition of medical assistance meant "medical services for needy individuals, provided by the State agency through payments (including payments of insurance premiums therefor) to persons, agencies, or institutions furnishing or procuring such services, but does not include (certain public institutions, tuberculosis, or mental illness)." (U.S. Congress, 1949)

The Federal share, based on the State per capita income, was limited to $6 per month for the average number of needy adults and $3 per month for needy children receiving payments under the State plan (U.S. Congress, 1949).

The Board's proposal was not approved by the House Committee on Ways and Means. It was too broad a proposal. When it seemed like no provision for medical assistance to needy persons would be included in the bill, I asked Elizabeth Wickenden, a long-time friend of mine in New York City, to remind Representative Walter Lynch (D., New York), a member of the Committee on Ways and Means, about introducing the concept of the "average" into the financial reimbursement provisions of public assistance. With Representative Lynch's help, I was able to develop such an amendment, which was adopted by the Committee and the Congress and incorporated into the 1950 Social Security Amendments (Public Law 734). Thus, in a miniscule manner, the Federal role in financing medical care for the poor began. Additional improvements were added in 1966 when the $6-$3 pooled plan of 1949 was adopted in the Social Security Amendments of 1956 as a method of financing medical assistance to the categorically needy (Schottland, 1956 and 1958).

In 1953, with the inauguration of President Dwight D. Eisenhower, the HEW Secretary Oveta Culp Hobby advocated a program of reinsurance of voluntary health insurance. This proposal failed to be enacted. In 1954, the HEW Under Secretary Nelson Rockerfeller, asked for a substitute proposal, and I assisted in the formulation of a Medicaid-type proposal for the needy. This proposal was rejected on cost grounds by the Bureau of the Budget.

Then, in 1960, Robert P. Burroughs[11] and HEW Secretary Arthur S. Flemming, urged President Eisenhower to endorse a Medicare-type plan financed through the social security system. The President initially did so, but subsequently withdrew his support because of the view that it was "socialized medicine" (Flemming, 1985). Secretary Flemming then developed a substitute proposal, submitted to Congress in 1960, based on an income threshold of $2,500 for an aged individual and $3,800 for an aged couple, to be financed from general revenues (Mitchell, 1960).

The House Committee on Ways and Means, under Chairman Mills, developed an alternative proposal. When the bill came to the Senate, in the summer of 1960, Senator Kerr requested me to review it and propose any changes to him within a few days. The changes I suggested were adopted without discussion by the Senate Finance Committee, the Senate, and by the Conference Committee. They became known as the Kerr-Mills bill (Mitchell, 1960).

Shortly thereafter, President-elect Kennedy appointed me Chairman of his Task Force, and subsequently, HEW Assistant Secretary for Legislation. All during the years 1960-65, I took the position that both Medicare-type and Medicaid-type programs were necessary and desirable and were not in conflict with each other. Mr. Mills readily accepted this view. The only other strong Medicare supporter I was able to persuade to take this view was my long-time friend, Senator Paul Douglas (D., Illinois), and Senator Albert Gore (D., Tennessee.)

The leading opponent was Senator Pat McNamara (D., Michigan), the Senator from my home state. Senator McNamara and his staff were critical of my views and my strategy (Perrin, 1966). Senator McNamara was not only strongly opposed to any deductible in Medicare, but to any income test. A number of other issues relating to the Older Americans Act and the Elementary and Secondary Education Act resulted in his criticism of my views and official positions. He vigorously criticized any "means tested" approach during an airplane ride to Ann Arbor, in 1964, when President Johnson went to the University of Michigan to make his Great Society speech. I went with the President because my son Christopher was graduating. The Michigan congressional delegation accompanied the President on Air Force One. Former Governor G. Mennen Williams was on the plane, as was Representative Martha Griffiths (D., Michigan), a member of the House Committee on Ways and Means. The President, however, never instructed me on how to handle Senator McNamara. None of the participants on the plane defended my position. The inclusion of Medicaid in the 1965 law would not have occurred without the explicit support of Chairman Mills.

Many people, since 1965, have called Medicaid the "sleeper" in the legislation. Most people did not pay attention to that part of the bill (embodied on pages 124-146 of a 296-page piece of legislation or discussed on pages 63-75 of a 264-page Committee Report under the heading "Improvement and Extension of Kerr-Mills Program"). Title XIX was not a secret, but neither the press nor the health policy community paid any attention to it because of the dazzling bewilderment of the adoption of Part B. The proponents of Medicare were delighted with their victory; the opponents were demoralized. Those of us concerned with the legislation became preoccupied with the Senate amendments and the Conference Committee compromises. The full awakening to the scope of the Medicaid legislation did not come until much later. The health policy community in 1965 was a small band of brothers and sisters concerned about the controversial elements in Medicare and unaware of the possibilities inherent in Medicaid. But the idea of Medicaid developed in my mind as early as 1942. I waited for the right time when someone would ask me to develop it into a law. The year 1965 was that time.

---

[11] Burroughs was a member of the 1953 "Consultants on Social Security." A pension consultant, he had a direct contact with President Eisenhower and initially had persuaded him to endorse Medicare.

Broadening and liberalizing requirement

Section 1903(e) and the 1965 Medicaid law provided:

> "The Secretary shall not make payments under the preceding provisions of this section to any State unless the State makes a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance, with a view toward furnishing by July 1, 1975, comprehensive care and services to substantially all individuals who meet the plan's eligibility standards with respect to income and resources, including services to enable such individuals to attain or retain independence or self-care."

I included this provision in the Medicaid law because I was acutely aware of the inadequacies of the State medical assistance plans in the 1960's. I knew we had to start from where we were, but my hope was to broaden and improve the program over a 10-year period. There was no opposition to this ambiguous and general provision in 1965. However, the attempt to implement this provision met resistance in New York State. Governor Nelson Rockefeller opposed its enforcement because of the cost, and the provision was repealed at his request in the 1972 amendments. A review of the New York State Medicaid plan in 1966-68 is provided in Myers (1970). Mr. Mills subsequently said he "was not aware really at the time of what it would do . . . I know later on Nelson Rockefeller and other governors told me that it required them to enlarge their programs that they operated under Kerr-Mills." (Mills, 1980). I have always thought this was an unfortunate and backward step. We might have had a more comprehensive "safety net" for the poor if this provision had remained in the law or had been modified to accommodate New York's special problems.

Summary

As I look back on the 45 years I worked on health policy issues, programs, and policies (1940-85) and, especially, the Medicare-Medicaid period (1950-68), I see the Medicare and Medicaid legislation of 1965 as part of a long-time process—a continuation from the past, a creation in a particular moment of time, an incremental evolution for the future. There have been some improvements since 1965, some setbacks, and some changes whose eventual impact is still unclear. We have learned much in the ensuing 20 years.[12]

I do not see the 1965 legislation in terms of good or bad, right or wrong, or in terms of an expanded or restricted role of the Federal Government. The Federal Government's intervention was necessary and desirable in 1965. It was not the only form that intervention could have taken. If the States had taken action during the period 1912-60, the roles of the Federal and State governments in health and medical care economics might have been different today. But individual States were unable to take up the opportunity in the face of the competitive costs to the employers in those States which enacted laws before others did. If the private insurance industry had supported specific proposals, which both the Republicans and Democrats offered during 1945-60, the current situation might be different. But they did not. They waited. They postponed action. They argued for delay. Time was running out.

Today, Medicare and Medicaid are part of a nationwide safety net. What their role will be in the future depends on many factors. But I am happy to have played a role in bringing these programs into being and giving a challenge to the health delivery sector of our economy to do better for present and future generations. I believe we will build a better program on the basic foundation of Medicare and Medicaid.

References

Brewster, A. W.: *Health Insurance and Related Proposals for Financing Personal Health Services*. Division of Program Research. Social Security Administration. Washington, U.S. Government Printing Office,1958.

Brewster, A. W.: *The Heath Care of the Aged, Background Facts Relating to the Financing Problem*. Division of Program Research. Social Security Administration. Washington. U.S. Government Printing Office, 1962.

Campion, F. D.: *The AMA and U.S. Health Policy Since 1940*. Chicago. Chicago Review Press, 1984.

Cohen, W. J.: *New Frontiers of the Kennedy Administration, The Texts of the Task Force Reports Prepared for the President*. Washington. Public Affairs Press, 1961.

---

[12] I have summarized these lessons in an article, "Medicare, Medicaid: 10 Lessons Learned," in *Hospitals* 59:44-47, Aug. 1, 1985.

Cohen, W. J., and Ball, R.: Social Security Amendments of 1965, Summary and legislative history. *Soc. Sec. Bulletin* 28:1-19, Sept. 1965.

Cohen, W. J., and Peerboom, P.: The Social Security Amendments of 1965. *1965, Year of Legislative Achievements in Health, Education, and Welfare*. Office of the Secretary, U.S. Department of Health, Education, and Welfare. Washington. U.S. Government Printing Office, 1966.

Cohen, W. J.: In First Person, An Oral History. Hospital Administration Oral History Collection. Chicago. American Hospital Association, 1983.

Corning, P. A.: *The Evolution of Medicare, From Idea to Law*. Research Report No. 29. Office of Research and Statistics, U.S. Department of Health, Education, and Welfare. Washington. U.S. Government Printing Office, 1969.

David, S. I.: *With Dignity, The Search for Medicare and Medicaid*. Westport, Conn. Greenwood Press, 1985.

Harris, R.: *A Sacred Trust*. New York. The New American Library, 1966.

Flemming, A. S.: Washington. Personal communication, 1985.

Hirshfield, D. S.: *The Lost Reform: The Campaign for Compulsory Health Insurance in the United States from 1932 to 1943*. Cambridge, Mass. Harvard University Press, 1970.

Marmor, T.: *The Politics of Medicare*. Chicago. Aldine Publishing Co., 1970, (revised edition 1973). London. Routledge and Kegan Paul, 1970.

Mills, W. D.: In First Person, An Oral History. Hospital Administration Oral History Collection. Chicago. American Hospital Association, 1983.

Mitchell, W. L.: Social Security legislation in the 86th Congress. *Soc. Sec. Bulletin* 23:5-15, Nov. 1960.

Murray, M. G.: Washington. Personal communication, 1944.

Myers, R. J.: *Medicare*. Homewood, Ill. Richard D. Irwin, 1970.

Myers, R. J.: *Social Security*. Third Edition. Homewood, Ill. Richard D. Irwin, 1985.

Perrin, R.: Oral History. New York. Columbia University Library, 1966.

Schottland, C. I.: Social Security Amendments of 1956, A summary and legislative history. *Soc. Sec. Bulletin* 19:12, Sept. 1956.

Schottland, C. I.: Social Security Amendments of 1950, A summary and legislative history. *Soc. Sec. Bulletin* 21:12, Oct. 1958.

Spiegel, A. D., and Podair, S.: *Medicaid: Lessons for National Health Insurance*. Rockville, Md. Aspen Systems Corp. 1975.

Speigel, A. D.: *The Medicaid Experience*. Germantown, Md. Aspen Systems Corp., 1979.

Stevens, R., and Stevens, R.: *Welfare Medicine in America, A Case Study of Medicaid*. New York. The Free Press, 1974.

Truman, H. S.: *Public Papers of the Presidents of the United States, Harry S. Truman, 1952-53*. Washington. July 1952.

U.S. Congress: House Committee on Ways and Means. Public Assistance Titles of the Social Security Act, Hearings on H.R. 2892. 81st Congress, First Session, 1949.

U.S. Congress: House Committee on Ways and Means. Public Assistance Titles of the Social Security Act, Hearings on H.R. 9120. 84th Congress, Second Session, 1956.

Weeks, L. E., and Berman, H. J.: *Shapers of American Health Care Policy*. Ann Arbor. Health Administration Press, 1985.

Williamson, K.: In First Person, An Oral History. Hospital Administration Oral History Collection. Chicago. American Hospital Association, 1983.

blank page

Twenty years of Medicare and Medicaid: Covered populations, use of benefits, and program expenditures

by Marian Gornick, Jay N. Greenberg, Ph.D., Paul W. Eggers, Ph.D., and Allen Dobson, Ph.D.

Marian Gornick is Director, Division of Beneficiary Studies, in the Office of Research, Health Care Financing Administration. She has been involved in research studies relating to Medicare and Medicaid since the programs were first implemented.

Jay N. Greenberg is on the faculty of the Heller Graduate School, Brandeis University. Dr. Greenberg serves as the Associate Director for Research of the school's Health Policy Center.

Paul W. Eggers is Chief, Program Evaluation Branch, in the Office of Research, Health Care Financing Administration (HCFA). Dr. Eggers' research activities involve the evaluation of the impact of HCFA programs on the beneficiaries.

Allen Dobson is Director, Office of Research, Health Care Financing Administration. Dr. Dobson is responsible for directing the planning and development of the Agency's research agenda.

Introduction

For the 20th anniversary of Medicare and Medicaid, this article provides a review of program data, focusing on the experience of the beneficiaries and the use and costs of services. Clearly, the 20th anniversary occurs at a time when important issues are being raised about the most basic features of these programs—the eligible populations, the covered services, and the financing—and when marked changes are taking place in the health care system. Thus, no useful review of Medicare and Medicaid today can also fail to note the major issues that confront the programs and the options that are being considered for new directions in the future.

There are concerns about how well the programs provide access to care for the most needy and vulnerable populations of the Nation, the equitable distribution of services, the appropriateness of the covered services, and the effectiveness and efficiency of the system in which the services are delivered and financed. Clearly, there are important decisions ahead, as the public deliberates which, if any, provisions of the Medicare and Medicaid laws (based on the needs and expediency of an earlier era) are unresponsive to present needs and goals, and as policy officials examine the strengths and weaknesses of the various options being considered to alter the programs.

The information presented in this article provides a basis for considering some of these options for the future. We review the 20-year experience of the Medicare and Medicaid programs, examining the subsets of the populations who are entitled to participate, trends in the use of services, and expenditures for those services.

A similar accounting was presented a decade ago, on the 10th anniversary of the Medicare program (Gornick, 1976). In the earlier article, a 10-year review of Medicare program data was given, examining the experience of the beneficiaries and their use and costs of services. The conclusion from that review was that Medicare had succeeded in accomplishing its primary goal of paying the major portion of large hospital and medical bills. Implementation of Medicare did not result in unbounded demand on the part of the beneficiaries for covered services; rather, major budgetary concerns arose from the rapid and persistent increase each year in the price of medical care services.

In the early years of Medicare and Medicaid, there were relatively few data bases, statistical reports, and research studies to draw on for program analysis. In more recent years, a wealth of statistical information and studies have become available. These include the article on national health expenditures published in the *Health Care Financing Review* each year (Gibson et al., 1984); *Medicare and Medicaid Data Book* (Sawyer et al., 1983); *Short-Term Evaluation of Medicaid: Selected Issues* (Rymer, Burwell, and Madigan, 1984); reports from the National Medical Care and Expenditure Survey (National Center for Health Statistics and National Center for Health Services Research, 1977) and the National Medical Care Utilization and Expenditure Survey (National Center for Health Statistics and Health Care Financing Administration, 1980); data from the National Center for Health Statistics, the U.S. Bureau of the Census, and the Social Security Administration; hundreds of published articles analyzing many aspects of the programs; and surveys and reports from other governmental agencies and from the private sector on the sociodemographic characteristics of the populations covered by Medicare and Medicaid. In general, Medicare program data are more complete than those available for the Medicaid program. This fact is reflected in numerous indepth studies of the Medicare program experience that cannot be duplicated for Medicaid.

Because the most fundamental feature of the Medicare and Medicaid programs—the eligible

---

The authors wish to express appreciation to Patricia Duffy who contributed significantly to this article by managing the production of the manuscript. They also thank Lee Sadler, Delores Russell, and Lorraine Miller for their assistance in typing and checking the data. Special credit is given to Karen Beebe and Vikki Latta who worked diligently to develop some of the latest program data.

populations—is being debated, it seems appropriate to concentrate not only on the Medicare and Medicaid program experience but also on certain aspects of the Social Security Administration's beneficiary population. Knowledge of the characteristics of those beneficiaries, and the basic links with the social security old age, disability, and social welfare programs, is necessary to understand the present composition and characteristics of those enrolled in Medicare and Medicaid. Of the more than 50 million people covered by the Medicare and Medicaid programs, only those Medicare enrollees entitled solely because of end-stage renal disease, about 30,000 persons, are not presently beneficiaries (or in related categories) of the social insurance and social welfare systems.

Despite the wealth of information that has been generated, there are inevitable data limitations (including time lags, inaccuracies, and lack of certain details) that restrict the completeness and depth of any program accounting. In this article, we use a few sets of data from among the many available to highlight what has been learned about the enrolled populations, their use of services, and program expenditures.

First we present an overview of the Medicare and Medicaid programs and a summary of current program and health sector issues of concern. Then we discuss the covered populations, the use of services, and program expenditures. Finally, we offer some broad conclusions on the 20-year experience of the two programs and future directions.

Overview of Medicare

A recurring issue in the long legislative debate that preceded the passage of the Medicare law was the lack of hospital insurance among the aged. A survey of the Nation in 1963, just before Medicare, showed that about three-fourths of adults under age 65 had hospital insurance; only 56 percent of persons 65 years of age or over had hospital insurance (Andersen, Lion, and Anderson, 1976). Yet the aged population was identified as being most at risk, with the highest rate of illness and the lowest income. Medicare was enacted into law on July 30, 1965, as Title XVIII of the Social Security Act. The program went into effect on July 1, 1966, to provide health insurance protection for the aged. The primary goal of the program was to increase access to health care services and to reduce the financial burden of the high costs of medical care. The 1972 Social Security Amendments expanded Medicare to provide coverage, beginning July 1, 1973, to two additional high-risk groups—disabled persons receiving cash benefits for 24 months under the social security program and persons suffering from end-stage renal disease.

Medicare was designed as a national, federally administered program with uniform eligibility and benefits and was tied to the Federal social insurance system. It has two parts: hospital insurance (HI), known as Part A, and supplementary medical insurance (SMI), known as Part B. The HI program was specifically designed to provide protection for acute-care needs, with benefits structured around episodes of illness. HI covers 90 days of inpatient hospital care in a benefit period, which begins the first day of hospitalization and ends when the beneficiary has not been an inpatient in a hospital or skilled nursing facility (SNF) for 60 continuous days. There is no limit to the number of benefit periods an individual may use. The program also provides a one-time (life-time) reserve of 60 days to use if a beneficiary exhausts the 90 inpatient hospital days available in a benefit period. In addition to inpatient hospital care, the hospital insurance program covers up to 100 post-hospital days in an SNF if the beneficiary is certified to require such care. The program also covers an unlimited number of home health agency (HHA) visits if the beneficiary is confined to the home and needs such services.

About 97 percent of the aged covered by HI enroll in the SMI program, which requires a monthly premium. SMI was designed to complement, in many respects, the HI program; it provides payments for physicians and related services and supplies ordered by the physician. It also covers outpatient services, rural health clinic visits, and home health visits for persons without Part A. The monthly premium was $3.00 in 1967 and $15.50 in 1985. Under "buy-in" agreements, most State Medicaid programs pay the premiums for Medicaid enrollees who qualify to participate in SMI.

Effective November 1, 1983, hospice benefits became available for persons who are terminally ill. The benefit has a sunset provision, expiring on October 1, 1986, unless extended by legislation. Enrollees can elect the hospice benefit for two 90-day periods and one 30-day period.

Drugs on an outpatient basis, dental care, routine eye examinations, and preventive services are not covered by Medicare. Long-term institutional services are not covered either.

To hold down program costs and to deter overutilization, the Medicare program, from the beginning, required beneficiary cost sharing. Under HI, the patient is required to pay an inpatient hospital deductible in each benefit period. The deductible approximates the cost of 1 day of hospital care. Coinsurance based on the inpatient hospital deductible is required for the 61st-90th day of inpatient hospital care (always equal to one-fourth of the deductible), for the 21st-100th day of SNF care (one-eighth of the deductible), and for the 60 lifetime reserve days for inpatient hospital care (one-half of the deductible). The patient is also liable for the cost (or replacement) of the first three pints of blood. In 1967, the inpatient hospital deductible was $40; in 1985, $400. Nearly 70 percent of Medicare enrollees have private "Medigap" policies, which primarily cover some or all of the deductibles and coinsurance under Medicare. About 15 percent of the aged and 21 percent of the disabled have Medicaid coverage also, and Medicaid usually assumes responsibility for the cost-sharing under Medicare.

Under SMI, in addition to paying a monthly premium, the beneficiary must meet a deductible (currently $75) each year. On each claim for payment, physicians can accept or reject assignment. Acceptance of assignment means that the physician agrees to accept as full payment the amount Medicare allows for the service. On assigned claims, the program reimburses 80 percent of allowed charges directly to the physician. Beneficiaries are liable for the remaining 20 percent (coinsurance) of allowed charges. On unassigned claims, the beneficiary is also liable for the difference between the physician's charge and the allowed charge; Medigap policies generally do not cover charges above Medicare's allowed charge.

Medicare has operated primarily on a fee-for-service basis for physicians and related services and on a retrospective cost-basis for hospital services. Claims are processed by fiscal agents, contracted by the Medicare program to review and pay the bills. Enrollees can also join health maintenance organizations (HMO's) and similar forms of prepaid care. Special reimbursement provisions apply to these organizations. The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 included major revisions to the Medicare law to encourage the growth in the number of HMO's and other comprehensive medical plans enrolling Medicare beneficiaries.

Through fiscal year 1983, hospitals were paid under a retrospective cost-based system whereby hospitals were reimbursed for any reasonable costs incurred in the provision of covered care to Medicare patients. Beginning October 1, 1983, payment rates were prospectively determined on a case basis. The Medicare hospital prospective payment system (PPS) uses diagnosis-related groups (DRG's) to classify cases for payment.

Medicare benefits and administrative expenses are paid from two separate trust funds. The HI trust fund is financed primarily through the employee and employer payroll tax on current earnings from employment covered under the Social Security Act. The taxes paid by current workers are used to pay for services received by current Medicare beneficiaries. The SMI trust fund is financed through premiums paid by, or on behalf of, persons enrolled in the program and by the Federal Government from general revenues.

Overview of Medicaid

Medicaid had its beginning in earlier medical assistance programs. The primary goal in the design of the program was to provide access to health care services for certain low-income persons. Medicaid was enacted into law on July 30, 1965, as Title XIX of the Social Security Act, and became part of the existing Federal-State welfare structure that assisted the poor.

Medicaid, supported by Federal grants and administered by the States, is limited to specific groups of low-income individuals and families. The program was designed to cover those groups or categories of people who are eligible to receive cash payments under one of the existing welfare programs established under the Social Security Act; that is, Title IV-A, the program of Aid to Families with Dependent Children (AFDC), or Title XVI, the Supplemental Security Income (SSI) program for the aged, blind, and disabled. This federally administered cash program was established by Congress in 1972, with payments beginning in January 1974. SSI was designed to replace the Federal-State programs of Old-Age Assistance (OAA), Aid to the Blind (AB), and Aid to the Permanently and Totally Disabled (APTD). In most cases, receipt of a welfare payment under one of these programs means automatic eligibility for Medicaid. In addition, States may provide Medicaid to the "medically needy," that is, people who are not recipients of cash assistance, but who fit into one of the categories of people covered by the cash assistance programs and whose income and assets fall within the medically needy standards or who spend-down, because of their medical bills, to the medically needy standards. Under general Federal guidelines, States set income and assets standards for cash assistance and Medicaid eligibility. Because there is considerable variation in the coverage of optional groups and in income standards across Medicaid jurisdictions, the degree to which individual programs cover the poverty population varies considerably.

Title XIX of the Social Security Act requires that every State Medicaid program offer certain basic services: hospital inpatient and outpatient care, laboratory and X-ray services, skilled nursing facility care for individuals 21 years of age or over, home health care for individuals eligible for SNF services, physicians' services, family planning, rural health clinic services, and early and periodic screening, diagnosis, and treatment for individuals under 21 years of age. In addition, States may provide a number of other services if they elect to do so, including drugs, eyeglasses, intermediate care facility services, inpatient psychiatric care for the aged and persons under 21 years of age, physical therapy, and dental care. States determine the scope of services offered, e.g., they may limit the days of hospital care or the number of physician visits covered.

Medicaid operates primarily as a vendor payment program. Payments are made directly to providers of service for care rendered to eligible individuals. Methods for reimbursing physicians and hospitals vary widely among States, but providers must accept the Medicaid reimbursement level as payment in full. Medicaid physician reimbursement is generally more stringent than Medicare. In long-term care facilities, individuals are required to turn over income in excess of their personal needs and maintenance needs of their spouses to help pay for their care. States may require cost-sharing by Medicaid recipients, but they may not require the categorically eligible to share costs for mandatory services. As noted earlier, most State Medicaid programs have buy-in agreements with

Medicare. Under these agreements, Medicaid assumes responsibility for the Medicare cost-sharing obligation of persons covered under both programs.

Medicaid is financed jointly with State and Federal funds. Federal financial participation varies with States' per capita income and currently ranges from 50 percent to 77.55 percent of program payments. Administration and Medicaid Management Information System costs are matched at other uniform rates.

States participate in the Medicaid program at their option. All States except Arizona currently have Medicaid programs. Arizona has a demonstration project of capitated health delivery under way, which is similar (excluding coverage of long-term care services) in eligibility and benefits to the Medicaid program. The District of Columbia, Puerto Rico, Guam, the Northern Marianas, and the Virgin Islands also provide Medicaid coverage. States administer their Medicaid programs within broad Federal requirements and guidelines. These requirements allow States considerable discretion in determining not only eligibility, but covered benefits and provider payment mechanisms. Some States also include in their Medicaid program persons known as "State-only" enrollees, who do not meet Federal requirements and hence do not qualify for Federal matching funds. As a result of State options and policy decisions, the characteristics of Medicaid programs vary considerably from State to State.

The Omnibus Budget Reconciliation Act (OBRA) of 1981 made major revisions to the Medicaid law. States were given substantially more flexibility in the administration of their programs as well as additional options, including the introduction of home and community-based service programs as alternatives to institutionalization.

Current program issues

With the passage of the Medicare and Medicaid programs, public concern focused on anticipated demand for health care services from those who would be newly entitled to publicly funded services. There was an absence of concern that price or unit cost might increase significantly (Klarman, 1966). It is near legendary now that it was costs, rather than patient demand (as measured by the number of physician office visits or hospital days of care), that spiraled the first year these programs were implemented and for many years that followed.

Several different factors in the health care system have been identified with the continuing increase in costs: the rise in wages and price levels in the health care industry; increases in the number of certain customary services such as laboratory tests; the development of new and costly medical technologies such as open-heart surgery; changes in the organization of care, such as the growth of intensive care units in hospitals and increases in personnel; and the growth of institutions for long-term care.

Factors often cited as giving impetus to these changes include: the increase in demand for more costly health care services, as a result of Medicare, Medicaid, and other third-party payment that removed the individual from the direct consequences of the cost of services; the response of health care providers to reimbursement methods that offered financial incentives to increase medical care spending; and the rising expectations in the Nation with regard to health care services.

As health care expenditures continued to increase well above the general rate of inflation, there was mounting pressure in the Federal sector to develop policies to promote cost effectiveness and cost containment. In the search for solutions, every aspect of the health care system came under scrutiny. Efforts were made to control duplication of resources and excess capital investment. New methods were tested for paying hospitals, with the primary goal of containing hospital budgets and capital growth. The reimbursement methods tested included incentive reimbursement schemes (sharing the savings of reduced costs) and prospective reimbursement mechanisms. Several States instituted hospital rate-review programs. Experiments were designed to test the value of a second opinion on reducing unnecessary elective surgeries.

The 1972 Amendments to the Social Security Act mandated several cost-control measures. Section 223 of the legislation authorized the Department of Health, Education, and Welfare to determine prospective per diem reasonable cost limits and to withhold payments to hospitals for unreasonable expenses.

The Amendments also established the Professional Standards Review Organization (PSRO) program to review the care received by all federally funded patients. A major emphasis of the PSRO program was to eliminate unnecessary hospital days. Congress also established a network of health systems agencies (HSA's) with the responsibility of overseeing area-wide health planning and resource development. Certificate-of-need programs were implemented to review large capital expenditures. The Federal Government also encouraged the growth of health maintenance organizations (HMO's) as a way of promoting the use of preventive services and decreasing the need for hospital care. In August 1971, the Federal Government implemented the Economic Stabilization Program, bringing the health care industry under mandatory controls until April 30, 1974. Following the rise in health care inflation during 1974-76, the Voluntary Effort was initiated in 1977 to encourage the health care industry itself to control costs. In 1982, the Tax Equity and Fiscal Responsibility Act (TEFRA) set limits on Medicare reimbursements for hospital costs at the per-case level and also placed a limit on the annual rate of increase for Medicare's reasonable costs per discharge.

The growth of Medicaid expenditures became a major concern not only to the Federal Government but to State and local governments as well. Medicaid expenditures in many States grew faster than State revenues. Much of the rapid expenditure increases in Medicaid outlays can be attributed to the growth in spending for long-term care services. To control the growth in Medicaid spending and to give States new options, the Omnibus Budget Reconciliation Act (OBRA) of 1981 changed some of the critical policy areas within Medicaid. Under Section 2176 of OBRA, States under a waiver may institute a variety of home- and community-based services for individuals who, "but for" the services, would be in long-term care institutions. To help bring hospital costs under control, OBRA granted the States new flexibility in the establishment of inpatient hospital reimbursement methodologies. Under Section 2175 of OBRA, States may institute a variety of programs (with and without waivers) to reduce costs by limiting the Medicaid provision that guarantees freedom of choice of provider. OBRA also contains several changes designed to reduce the number of persons eligible for Medicaid.

In addition, OBRA provided for the reduction of Federal matching funding for 3 years, beginning October 1, 1982, subject to certain exemptions. The Tax Equity and Fiscal Responsibility Act of 1982 permitted States to impose nominal copayments with certain limitations, to reduce program outlays and instill cost consciousness on the part of the recipient.

Some of these approaches were judged to be generally ineffective or inconclusive. Others were terminated or altered. The results of some of these innovations have been slow to take hold; others are too new to measure their results. Noteworthy among all these approaches has been the 1983 Amendments to the Social Security Act, which mandated the Medicare prospective payment system for hospitals, a major change that is generally believed to have had a significant impact even in its first year. Following is a discussion of prospective payment and other issues that are likely to be important concerns as Medicare and Medicaid enter their third decade.

Hospital prospective payment under Medicare

The national payment rate for hospitals based on diagnosis-related groups (DRG's) has been under way since October 1983, and it is scheduled to be phased in over 3 years. In its first year, the effects of the change from retrospective cost-based reimbursement principles for hospital payment to the incentives inherent in a prospective payment system (PPS) have been striking. For the first time since the implementation of Medicare and Medicaid, a cost-containment program for hospital services has been implemented that holds the promise of being a major structural change, one that will enable Medicare to predict annual increases in hospital expenditures.

Although the average length of stay was expected to fall, the actual decrease experienced since the inception of PPS is more pronounced than would have been projected based on Medicare historical trend lines. Contrary to nearly universal expectations, admission rates under PPS have fallen. Supply capacity has also been affected; the number of short-stay hospital beds has fallen, and occupancy rates are the lowest since data have been available on this measure. At this time, there is no indication of significant shifts in utilization from inpatient hospital to SNF, HHA, or outpatient settings.

Prospective payment systems, in general, are intended to provide an economic incentive to restrain resource use and to maximize efficiency, without adversely affecting access or quality of care. The new hospital prospective payment system introduced immediate concerns, including finding methods for refining the system to take into account severity of illness. The most important concern, however, relates to assuring access and quality of care. Other issues include finding methods for paying for medical education and capital expenditures. The effectiveness of the hospital PPS under Medicare, as well as future prospective payment systems for other types of providers, depends on prudent and judicious use of strategies that contain costs, but that also do not jeopardize access and quality of care.

Peer Review Organizations

The original Medicare and Medicaid legislation mandated utilization review to assure that federally reimbursed health care services were furnished in an efficient and cost-effective manner. In 1972, the Professional Standards Review Organizations (PSRO) program was enacted to increase the effectiveness of Medicare review. Congress modified the requirements for peer review and passed new legislation in 1982, replacing the grant-based PSRO program with a new contract-based Peer Review Organizations (PRO) program for utilization review and quality control. The period of the contracts are initially for 2 years, and they are renewable biennially. Contracts with PRO's must specify objectives to be achieved over the contract period; an assessment of the organization's performance will be in terms of meeting those objectives. PRO review activities will be directed toward those quality, cost, and utilization areas most likely to be affected by the new hospital prospective payment system.

New technologies

The development, assessment, and coverage of new technologies are issues that Medicare and Medicaid face in this decade. A concern under the hospital prospective payment system is to find methods that can be used to adjust the current classification system to reflect technological changes, and to assure that the prospective system does not inhibit the development and diffusion of technologies that can enhance the quality of care.

Although retrospective, cost-based, third-party reimbursement is considered to be the major factor contributing to the explosion in hospital costs, it facilitated the expansion of the hospital sector and encouraged the upgrading of hospital facilities and services and improved access to the hospital system by the elderly, in general, and the disadvantaged elderly, in particular (Lave, 1984).

The revised payment system offers an opportunity to moderate the flow of new technology into the health care sector. Toward this end, it is generally believed that the health care system should develop a more systematic approach to review and assess the effectiveness and efficiency of new and existing technologies. The Medicare and Medicaid programs also face decisions relating to coverage of the most highly technological and costly services, such as organ transplants.

Physician payment under Medicare

Medicare's Part B program is the third largest Federal domestic program, exceeded only by the social security cash benefit program and Medicare's Part A program. Since its inception, Medicare has been paying physicians on the basis of submitted charges for each unit of service. During the past 20 years, the rate of growth of Medicare reimbursements for physicians' services has been nearly equal to the rate of growth of reimbursement for inpatient hospital care.

To constrain the rate of growth of Part B outlays for a period of time, the Deficit Reduction Act of 1984 placed a freeze on Medicare maximum payment levels for a 15-month period beginning July 1, 1984, and introduced the concept of "participating physicians" (physicians who accept assignments for all services for this period). Incentives to become "participating physicians" were introduced and resulted in substantial increases in assignment. In the past 20 years, the physician-to-population ratio has increased 41 percent, while the hospital-beds-to-population ratio has risen only 12 percent (Ermann and Gabel, 1985). The increase in the Nation's supply of physicians may be a factor that leads to increased willingness to accept assignment of claims and, eventually, revised payment systems.

There is general agreement that physician payment under Medicare needs to be changed. The development of fee schedules for physicians' services and more general prospective payment systems, such as inpatient physician DRG's, were considered as possible reform alternatives. However, these approaches were viewed as impediments to the overall objectives of Medicare reform. Such reform is likely to be based on more competitive strategies that use capitation as the basic payment mechanism. Under this reform, the objective is to have a single capitated payment for physician, hospital, and other Medicare-covered services. Demonstrations of various capitated approaches are currently under development. These demonstrations will consider quality, beneficiary access, and out-of-pocket liability as well as cost effectiveness of service provision.

Capitated systems

For the first 15 years of the program, enrollment of Medicare beneficiaries in HMO's (or prepaid group practices) was relatively low. In 1981, 595,000 Medicare beneficiaries (a little more than 2 percent) were enrolled in capitated systems. The 1982 TEFRA included legislation to encourage enrollment in HMO's and other competitive medical plans (CMP's). In 1985, the number of Medicare beneficiaries enrolled in HMO/CMP and group practice prepayment organizations reached 1,117,000 (3.7 percent of Medicare enrollees).

The savings from HMO's are believed to stem from the incentives for efficiency in a prepaid capitation payment method where the health care provider receives a fixed amount for assuming the responsibility for an enrollee's care instead of fee-for-service payments. It is also believed that increasing competition in the health care sector holds the promise of further constraining health care costs; if individuals are offered incentives to choose efficient, less costly health delivery systems, then providers will compete in the market for enrollees. In the effort to promote competition in Medicare, additional options are being considered, including testing geographic capitation approaches. Also being discussed is a voucher system for enrollees to use toward the purchase of coverage from one of a number of competing health plans.

There are four major issues relating to fully capitated systems under Medicare. The first is to find adequate methods to determine capitated payments that reflect differences in beneficiary health status and potential use of resources. The second is to control favorable or unfavorable selection practices, on the part of providers and beneficiaries, so that competition is on the basis of efficiency rather than unfair market advantages (Eggers, 1980; Eggers and Prihoda, 1982). The third is to find ways of monitoring these capitated systems, especially to assure that high-risk persons have access to services and that quality of care is maintained. The fourth relates to the wide geographic variations in Medicare reimbursements across areas and within regions, and the extent to which these differences should be taken into account in future payment systems.

Other competitive efforts

Other significant changes are taking place in the organization and delivery of care. In the private sector, a marked increase has occurred in the number of for-profit hospital chains. Currently, there are 28 investor-owned hospital chain systems in the United States. In 1984, these chains increased by 15 percent the number of hospital beds they own or manage; they now control about 13 percent of all the non-Federal short-stay hospital beds in the United States (Johnson, 1985).

The development of multihospital systems is occurring not only in the for-profit hospital sector, but throughout the hospital industry. Approximately one-third of the Nation's hospitals are part of multihospital systems, defined as corporations that own, lease, or manage two or more acute-care hospitals (Weil, 1985). These systems have been evolving and growing through horizontal expansion (acquiring acute care facilities) and vertical diversification (adding other types of facilities). Other growing nonhospital-based delivery systems include freestanding ambulatory surgery centers and emergency and urgent care centers. The role of risk taking (underwriting) is also changing rapidly as insurance companies acquire HMO's, and hospital chains purchase insurance companies. The impact of these developments on health expenditures and the health care sector in the future is not yet known.

As our health system becomes a competitive industry, cross-subsidies and cost-shifting (which were common in the past) are disappearing. This has led to a dilemma for community hospitals, because many of them have been providing considerable amounts of uncompensated care to the uninsured. Public hospitals and teaching hospitals bear a larger share of uncompensated care relative to their revenues, compared with the nonteaching voluntary and investor-owned hospitals (Wilensky, 1984). When the costs of uncompensated care cannot be easily allocated across payers, institutions must either reduce the amount of uncompensated care they provide or find other sources of revenues. Thus, the financing of uncompensated care has become a growing health policy issue that will need to be addressed by legislators.

Long-term care financing and delivery

A general concern exists in the Nation about the aging of the population and the need to develop policies that will provide mechanisms for the financing and delivery of long-term care services. Medicare is an acute-care program. The burden for providing payment for long-term care has fallen on Medicaid. Many feel that the program cannot carry this burden indefinitely. Currently, few of the aged have insurance for nursing home care or for long-term care services in the home. Consequently, a majority of the aged face the risk of financial ruin and dependency from an extended long-term illness or disability that requires personal and nursing care services. The current financing dilemma is likely to worsen in the next three decades as the proportion of the population that is 65 years of age or over rises.

Related to the financing issue is the lack of availability of appropriate and less costly long-term care services in many communities. The impaired elderly are likely to require personal care and support services as much as medical care services. Except in an institutional setting, the combination of such services is often difficult to obtain by those with long-term care needs. Most aged people with functional limitations prefer to remain in the community and maintain their independence as long as possible. Consequently, there is a major concern to find new approaches toward caring for the needs of the elderly in the community.

Entitlement under Medicare

Currently, Medicare covers nearly the entire population 65 years of age or over. In 1984, 13 percent of the aged Medicare population consisted of persons 65 and 66 years of age. Because of increased life expectancy and changes in the future social security retirement age, recommendations have been made to increase the age of Medicare entitlement to 67 years. If people were employed until age 67, the majority would have health insurance coverage under their employment. For those who retire earlier, obtaining private health insurance until age 67 or later becomes a new issue. Although the majority of people in their sixties are in good health, there are many who retire early because of work limitations, and this may cause difficulties in obtaining stop-gap health insurance coverage.

A more profound issue has been raised about Medicare's universal coverage of the aged. Because the overall economic position of the aged has improved during the past two decades, the issue has been raised as to whether or not Medicare should be limited or more focused on the needy aged. If Medicare became a needs-tested program, new issues would arise relating to developing adequate private insurance mechanisms for the nonpoor aged population throughout their retirement years.

Eligibility under Medicaid

Access to Medicaid varies significantly by State. During the past two decades, a recurring issue has been the widely varying policies that States have chosen in determining the kinds of optional groups to include in their Medicaid programs as well as the standards set for income and assets, which are the basis for eligibility. Consequently, similar kinds of needy persons do not have equal access to Medicaid coverage throughout the Nation. In addition, because Medicaid is limited to the existing welfare categories, needy persons 21-64 years of age are ineligible for Medicaid unless they are disabled or in families with dependent children.

Financing Medicare trust funds

The Part A trust fund depends upon intergenerational transfers through the payroll tax on current workers and employers. Revenues to the trust fund depend on the number of workers in covered employment, the Part A tax rate, and the wage base. The ratio of workers to cash beneficiaries under the social security retirement and disability programs declined from 4.0 to 1 in 1965, to 3.3 to 1 in 1985. It is projected that the ratio will decline to 3.1 to 1 during the next 25 years. In 1985, employees and employers each contributed 7.05 percent in social security taxes up to maximum taxable earnings of $39,600.

The Part B trust fund is financed by enrollee premiums and from general revenue tax receipts. The general revenue share of Part B has grown from 50 percent in 1971 to 74 percent in 1983. Through 1983, Part B premiums could not increase more than the increase in social security benefits. Beginning in 1984, premiums were established so as to cover 25 percent of the costs incurred by the aged. A major issue under Part A and Part B is whether the share the aged contribute can be increased without undermining the principals of insurance and without placing an undue burden on low-income aged beneficiaries.

Implications for the future

These recent health system changes, including prospective payment, alternative organizational arrangements, and the competitive model in the health care sector, are likely to have profound effects on the Medicare and Medicaid programs. Although these new approaches are expected to control the escalation in costs, which have been a major budgetary concern during the past 20 years, the market-oriented changes in the health care system are currently shifting the focus of concern toward assuring access and quality of care. The directions taken on the major program issues, including eligibility, financing, coverage of new technologies, and the development of long-term care policies, will affect how well the Medicare and Medicaid programs meet the needs of the most vulnerable and high-risk populations in the Nation. The following sections on the 20-year experience of the beneficiaries present background information and program data that are relevant to policy directions and future program changes for Medicare and Medicaid.

Covered populations

In 1985, there were an estimated 238 million people in the United States. Over 50 million (more than one out of five) were enrolled in either Medicare or Medicaid or both programs. Following is a description of demographic and socioeconomic characteristics of program enrollees, by major subgroups. Under Medicare, the subgroups are: the aged, the disabled, and persons with end-stage renal disease (ESRD). Under Medicaid, the subgroups are AFDC and SSI. There are also persons with joint eligibility for both programs (dual enrollees). Because the rationale for public health care financing programs is based on the economic status of the beneficiary populations, a discussion of trends in the economic status of persons 65 years of age or over and of children under age 18 is also presented. These two age groups together account for more than 80 percent of all Medicare and Medicaid enrollees.

Aged population under Medicare

The Medicare legislation made nearly the entire population in the Nation 65 years of age or over eligible for coverage under Medicare's hospital insurance (HI) program. During the 11 months between the time the law was enacted, July 30, 1965, and the first day of operation, July 1, 1966, 19.1 million aged persons were enrolled in Medicare's HI program. The vast majority of these people were automatically entitled to hospital insurance because they were social security and railroad retirement cash beneficiaries. A special transitional provision of the law brought in most of the remaining aged population, about 2 million people. Relatively few aged persons (an estimated 150,000) were excluded; principally they were aliens, or Federal civil service employees and annuitants. Coverage under Medicare's SMI program requires voluntary enrollment; 17.7 million signed up the first year. In the following years, the proportion of HI aged enrollees who were enrolled in SMI was about 97 percent. Thus, from its beginnings and throughout its 20-year history, Medicare has been a nearly universal health insurance program, providing a uniform set of benefits for the population 65 years of age and over. This universal program became even more so with the 1982 amendment that included the Federal civil service under Medicare.

As shown in Table 1, during the period 1966-84, the Medicare population increased by 42 percent, from 19.1 million to 27.1 million. During this same time period, the Nation as a whole increased by only 21 percent (U.S. Bureau of the Census, 1985). The oldest age group, people 85 years or over, increased by 134 percent from 1.2 million to 2.8 million persons, a rate of increase far greater than that experienced by the groups 65-74 and 75-84 years of age. Medicare population growth was more than twice as great in the South and West as in the Northeast and North Central census regions.

Increases in the Medicare population during these two decades reflects, in part, increases in longevity in the United States. Life expectancy, at birth and at age 65, has grown significantly during this century. In 1900, life expectancy was only 49.2 years; by 1984, it had increased to 74.7 years (Table 2). Declining death rates from heart disease, cerebrovascular disease, influenza, and other causes of death contributed to the growth in the elderly population (Rice and Feldman, 1983). Persons who reached age 65 in 1984 can expect to live, on average, 16.8 additional years, or more than 2 years longer than persons who were 65 years of age when Medicare began.

Projections made by the U.S. Bureau of the Census (1985) indicate that the population 65 years of age or over will increase faster than the population under age 65 for the remainder of this century and for the first two decades of the 21st century. Increases in life expectancy, as well as lower birth rates, mean that the traditional population pyramid (consisting of a broad base of children 0-4 and 5-9 years of age, a vertex of

Table 1

Number and percent distribution of Medicare hospital insurance enrollees 65 years of age or over, by age, sex, race, and census region: July 1, 1966 and July 1, 1984

Age, sex, race, and census region	Enrollees 65 years or over				
	1966		1984		
	Number in millions	Percent	Number in millions	Percent	Percent increase 1966-84
Total	19.1	100	27.1	100	42.1
Age					
65-74 years	12.0	63	15.8	58	31.8
75-84 years	5.9	31	8.5	32	44.4
85 years or over	1.2	6	2.8	10	134.2
Sex					
Male	8.1	43	10.9	40	34.3
Female	11.0	57	16.2	60	47.9
Race					
White	17.0	89	23.9	88	40.5
All other	1.4	8	2.4	9	64.4
Unknown	0.6	3	0.8	3	32.9
Census region					
Northeast	5.0	26	6.2	23	24.3
North Central	5.5	29	7.0	26	25.8
South	5.4	28	8.7	32	61.7
West	2.8	15	4.6	17	64.0
Outlying, foreign, and unknown	0.3	2	0.5	2	79.5

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System.

Table 2

Life expectancy at birth and average remaining years at age 65: United States, selected years 1900-84

Year	At birth	At age 65
	Life expectancy in years	
1900	49.2	11.9
1930	59.3	12.3
1950	68.1	13.8
1960	69.9	14.4
1965	70.2	14.6
1970	70.8	15.0
1974	71.9	15.6
1977	73.2	16.3
1981	74.2	16.7
1982	74.6	16.8
1983	74.6	16.7
1984[1]	74.7	16.8

[1] Provisional data.

SOURCE: National Center for Health Statistics: Data from the National Vital Statistics System.

relatively few in the group 80-84 years of age, and fewer still 85 years of age or over) will no longer prevail by the year 2020. During the first two decades of Medicare, people 65 years of age or over represented approximately 1 in 10 of the Nation's total. By the year 2030, about 1 person in 5 will be 65 years of age or over, and the "oldest-old," that is, those 85 years of age and over, will number more than 8 million people. The aging of the population projected for the United States is also projected for every industrialized nation in the western world as well as for Japan.

In the past, discussions of the aging of the population have often been based on stereotyped images of people 65 years of age or over. The aged have often been portrayed as frail or mentally impaired. More recently, studies and surveys of the aged show a heterogeneous population, spanning 30-35 years, with a range of physical and mental attributes that greatly overlap those of younger age groups. In the 1980 National Medical Care Utilization and Expenditure Survey (NMCUES), 63 percent of the noninstitutionalized population 65 years of age or over rated their health as "excellent or good," and 60 percent had no limitations in major or outside activities (Kasper, 1985). The probability of functional impairment, however, rises steadily with age. The Long-Term Care Survey of 1982 found that 19.1 percent of Medicare enrollees were living in the community with some limitations in the activities of daily living (ADL), such as bathing or dressing, and/or limitations in the instrumental activities of daily living (IADL), such as shopping for groceries or doing housework. The 1980 Census found that 4.6 percent of the population 65 years of age or over were in homes for the aged, including nursing and convalescent homes. Of those institutionalized, 74 percent were women. As shown in Table 3, there is a steady rise in impairment and institutionalization as age increases. In the group 65-69 years of age, 12.8 percent were not in institutions but had ADL or IADL limitations; 1980 Census data indicate that 1.1

Table 3

Estimated percent of aged persons with functional limitations, by living arrangements, age, sex, and race: United States

Age, sex, and race	Number of Medicare aged enrollees in thousands July 1982	Percent of Medicare enrollees with ADL limitations and living in the community 1982[1]	Percent of Medicare enrollees with ADL or IADL limitations and living in the community 1982[1]	Percent of aged persons institutionalized 1980[2]
Total	26,539.6	12.6	19.1	4.6
Age				
65-69 years	8,652.1	7.7	12.8	1.1
70-74 years	7,021.6	9.7	15.8	2.1
75-79 years	5,063.9	13.7	21.1	4.3
80-84 years	3,284.9	19.1	27.8	9.0
85 years or over	2,617.4	26.6	34.5	18.7
Sex				
Male	10,652.6	10.6	17.1	3.0
Female	15,887.4	14.0	20.6	5.8
Race[3]				
White	23,396.5	12.5	18.7	4.9
All other	2,371.9	18.5	28.5	3.3

[1] Activities of daily living (ADL) include bathing, getting in and out of bed, etc. Instrumental activities of daily living (IADL) include shopping for groceries, housework, etc.

[2] Aged persons in homes for the aged, including nursing and convalescent homes.

[3] Those of unknown race totaled 0.8 million people.

SOURCES: (Macken, 1985; U.S. Bureau of the Census, 1984).

percent in that age range were institutionalized. By age 85 years or over, the corresponding figures were 34.5 percent and 18.7 percent. These findings clearly indicate that needs for long-term care services will be affected by the aging of the population. Yet, even among those 85 years of age or over, substantial diversity is evident. If approximately 35 percent are living in the community with some functional limitations and about 20 percent are in homes for the aged, including nursing and convalescent homes, then about 45 percent of all persons 85 years or over can be assumed to be living in the community free of functional limitations. These data support the cautionary warning Binstock (1985) raises against unwarranted stereotyping of even the oldest-old.

Disabled population under Medicare

In 1972, major revisions to the Social Security Act extended Medicare coverage, beginning July 1, 1973, to disabled persons under age 65 receiving social security or railroad retirement cash benefits because of disability, and persons suffering from end-stage renal disease (ESRD). Surveys by the Social Security Administration in 1966 and 1972 showed that disabled persons used more health care services, had less private health insurance coverage, and had higher out-of-pocket expenses than the nondisabled population (Krute and Burdette, 1981; Stanley and Swisher, 1969; Brehm and Cormier, 1970; Duchnok, 1981; Ferron, 1981; Advisory Council on Social Security, 1965). For the disabled group, Medicare coverage begins only after the disabled person has received cash benefits for 24 months. For the ESRD population, coverage begins 3 months after the beginning of maintenance dialysis. The 3-month waiting period is waived for a person receiving a transplant or for those who initiate a program of self-care dialysis.

The social security disability program was established in 1956 to provide cash benefits to disabled workers. These disabled workers must first meet insured status requirements relating to the necessary quarters of employee contributions to the disability trust fund. Second, they must meet the social security definition of disability: the inability to engage in any substantial gainful activity by reason of an impairment that can be expected to result in death or last for a continuous period of not less than 12 months. In addition to disabled workers, the disability program covers disabled dependents who are adults, age 18 or over, who were disabled in childhood, and disabled widows or widowers who are 50 years of age or over.

Results from the 1978 Survey of Disability and Work (Social Security Administration, 1978), in which information was collected about the characteristics of the severely disabled population (defined as persons unable to engage in gainful work) between 18 and 64 years of age in the Nation in 1978, are shown in Table 4. The Survey found 10.9 million noninstitutionalized severely disabled persons, of whom 2.9 million

Table 4

Number of noninstitutionalized persons 18-64 years of age who are severely disabled, by selected characteristics: United States, 1978

Selected characteristic	U.S. population 18-64 years	Severely disabled persons	
		Total	SSA disability beneficiaries
Number in millions	127.0	10.9	2.9
Percent 55-64 years	16.0	46.0	57.0
Percent male	49.6	43.2	65.9
Percent black	10.6	16.8	14.0
Median years of school completed	12	10	10
Percent below poverty level	8.1	22.1	15.8

SOURCE: (Social Security Administration, 1978).

persons (26.6 percent) were social security disability beneficiaries. Since the social security disability program is tied to covered employment, it is not surprising that a high proportion of those receiving disability benefits, 65.9 percent, were male, although males constituted only 43.2 percent of the total severely disabled population.

In 1978, about 16.8 percent of the severely disabled population were black people, a figure nearly 60 percent higher than the proportion of black people (10.6) in the population surveyed. For the Nation as a whole, 8.1 percent of people 18-64 years of age were living below the poverty level; in the severely disabled population, 22.1 percent were living below the poverty level. For those who were social security cash disability beneficiaries, the proportion living below the poverty level was less, 15.8 percent, although it was still nearly twice as high as the general population in that age range.

As noted earlier, the Medicare program covers disabled beneficiaries only after they have been receiving social security cash benefits for 24 months. Of all persons awarded disability benefits in 1975, approximately 11 percent died before meeting the 24-month waiting period for Medicare coverage (Lubitz and Pine, 1985). Thus, because of the eligibility requirements of both the social security cash disability program and the Medicare program, Medicare covers about one-fourth of the severely disabled population in the Nation.

When Medicare coverage for the disabled began on July 1, 1973, there were 1.7 million Medicare enrollees (Table 5). Of these enrollees, 79.3 percent were disabled workers, 16.4 percent were adults disabled in childhood, and 3.9 percent were widows (with a few widowers). The population entitled solely because of ESRD was only 0.4 percent of the newly entitled.

Disabled workers under Medicare are primarily male and predominantly 45 years of age or over. Adults disabled in childhood have the reverse age pattern, with the majority under 45 years of age. More than one-half in this category are mentally retarded, and about 25 percent are institutionalized (Cormier, 1985). Disabled widows and widowers make up a group that is nearly all women and predominantly 60-64 years of age.

Between 1973 and 1984, the disabled population under Medicare increased 66.6 percent, while the aged population increased 25 percent. The relatively high increase in the Medicare disabled population reflects the accelerated growth of the social security cash disability program during the late 1960's and early 1970's. Medicare enrollment of the disabled peaked in

Table 5

Number and percent distribution of disabled Medicare hospital insurance enrollees under age 65, by type of entitlement: July 1, 1973, and July 1, 1984.

Type of entitlement	Enrollees under age 65				Percent increase 1973-84
	1973		1984		
	Number in thousands	Percent	Number in thousands	Percent	
Total	1,731	100.0	2,884	100.0	66.6
Workers	1,372	79.3	2,310	80.1	68.4
Adults disabled since childhood	284	16.4	460	16.0	62.0
Widows and widowers	68	3.9	85	2.9	25.0
End-stage renal disease[1]	6	.4	30	1.0	400.0

[1] Entitled solely because of end-stage renal disease (ESRD). Aged persons in Table 1 and disabled persons in above categories may also have ESRD.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System.

1981, when the total HI enrollment was nearly 3 million, and it has declined in each subsequent year. In 1984, enrollment was 2.9 million.

Medicare's disabled population has a much higher mortality rate than the general population. A recent study of the disabled population under Medicare showed that their mortality rate was 6.6 times the mortality rate of the general population 20-64 years of age. The relatively poor health status of the disabled population under Medicare is further illustrated by the finding that the mortality rate of the Medicare disabled population 60-64 years of age was twice that of the Medicare aged population in the group 65-69 years of age (Lubitz and Pine, 1985).

End-stage renal disease enrollees

The 1972 Amendments to the Social Security Act also provided coverage to one group of people with catastrophic illness, those with end-stage renal disease. The term end-stage renal disease (ESRD) is a generic one, used to describe a wide variety of diseases that result in terminal failure of the kidneys. There are two basic treatments: transplantation and dialysis. Before Medicare coverage, when rationing of scarce dialysis machines was the rule, the vast majority of people with ESRD could not get services and died.

Transplantation and dialysis greatly improve the chances of survival for ESRD patients. Patients receiving a kidney transplant have a 1-year survival rate of 92 percent. Dialysis patients from age groups similar to transplanted patients have a 1-year survival rate of 87 percent. However, in subsequent years, survival for transplant patients greatly improves while survival rates for dialysis patients remain essentially unchanged. Therefore, long-term patient survival is greater with a kidney transplant than with maintenance dialysis (Krakauer et al., 1985).

The impact of Medicare coverage on access to ESRD services was dramatic. Before the 1972 Amendments, selection criteria were rigid; those selected were people with the best chance of returning to work while on dialysis. Some important characteristics of the ESRD population before and after Medicare coverage are shown in Table 6. In 1967, ESRD patients on dialysis were predominantly male (75 percent), white (91 percent), with at least a high school education (72 percent), and under age 55 (91 percent). By 1978, there were striking gains in access, and the ESRD dialysis population more closely resembled the actual prevalence of ESRD in the U.S. population: female (51 percent), black (35 percent), not high school graduates (46 percent), and over age 55 (46 percent) (Evans, Blagg, and Bryan, 1981).

Table 6

Social and demographic characteristics of the hemodialysis patient population

Characteristic	1967	1978
	Percent distribution	
Sex		
Male	75.0	49.2
Female	25.0	50.8
Race		
White	91.0	63.7
Black	7.0	34.9
Other	2.0	1.4
Education		
Junior high school or less	10.0	28.7
Some high school	17.0	17.2
High school graduate	27.0	28.4
Some college	20.0	18.2
College graduate	12.0	5.7
Postgraduate school	13.0	1.8
Unknown	1.0	0.0
Age		
Under 25 years	8.0	3.4
25-34 years	24.0	10.0
35-44 years	32.0	14.6
45-54 years	27.0	25.8
55 years or over	7.0	45.7
Unknown	2.0	0.5
Marital status		
Single	16.0	13.0
Married	79.0	61.8
Separated	5.0	6.3
Divorced		7.4
Widowed		11.5
Employment status		
Employed	41.7	18.4
Unemployed	38.3	17.7
Disabled	13.2	53.6
Student		(1)
Retired		10.2
Other	0.0	0.1
Unknown	6.8	0.0

[1] Not coded.

SOURCE: (Evans, Blagg, and Bryan, 1981).

Medicare coverage for ESRD began on July 1, 1973. In 1974, the first full year of coverage, there were 15,993 persons[1] identified as having ESRD (Table 7). Of these, 4,868 were 65 years of age or over and entitled to Medicare under the aged program. Of the population under age 65, about one-third were entitled under the disability program and two-thirds were entitled solely because of ESRD.

The number of people being treated for ESRD under Medicare increased over five-fold by 1983, to 81,873 persons. Much of the rapid growth was in the early years of the program, reflecting the fact that

---

[1] To analyze the total number of persons being treated for ESRD and the use and costs of their services, the sections in this article covering ESRD include data for Medicare beneficiaries with ESRD who are eligible as aged or disabled enrollees.

Table 7

Persons with end-stage renal disease enrolled in Medicare hospital insurance, by age, sex, and race: July 1, 1974, and July 1, 1983

Age, sex, and race	Number of enrollees		Percent increase 1974-83
	1974	1983	
Total	15,993	81,873	412
Age			
0-14 years	211	1,135	438
15-24 years	1,075	4,599	328
25-34 years	1,774	10,938	517
35-44 years	2,161	12,508	479
45-54 years	3,069	14,750	381
55-64 years	2,836	18,957	568
65 years or over	4,868	18,985	290
Sex			
Male	9.071	45,539	402
Female	6,321	36,332	425
Race			
White	11,738	54,360	361
All other	3,944	25,842	555
Unknown	311	1,671	437

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System.

persons who otherwise would have died were now receiving treatment. Enrollment in 1975 and 1976 increased by 42 percent and 27 percent, respectively. By 1983, the rate of growth was down to 9 percent.

Increases over time varied greatly by age, race, and to a lesser degree, sex. Between 1974 and 1983, the largest increase by age occurred for persons 55-64 years of age; the smallest increase was for persons 65 years of age or over, which reflected, in part, the high mortality rate for ESRD persons over age 65 (Eggers, Connerton, and McMullan, 1984). The number of persons 15-24 years of age with ESRD also increased at a relatively low rate, reflecting, in part, the high rate of transplantation; in this age group, almost one-half of dialysis patients receive a transplant in any year. For those whose transplants still function after 3 years and who are not otherwise disabled, Medicare entitlement is terminated. Between 1974 and 1983, ESRD enrollment increased more for females (425 percent) than for males (402 percent), and was much greater for races other than white (555 percent) than for white people (361 percent). The all other racial group was 25 percent of the Medicare ESRD population in 1974 and 32 percent in 1983.

The increase in the number of people treated for ESRD reflects, in part, an increase in the kinds of cases being treated. The increase is greatest for people whose renal failure was caused primarily by hypertensive disease or diabetic nephropathy (Eggers, Connerton, and McMullan, 1984).

Some people suffering from ESRD are not covered by Medicare. The 3-month waiting period is one reason; another is not meeting the insured status from covered employment under the social security program. In a study of unentitled ESRD patients in 1981, it was estimated that there were 8,500 patients not entitled to Medicare benefits. One-half were awaiting entitlement; the other one-half were primarily being supported by other public programs, that is, Medicaid, Veterans' Administration, and State ESRD programs (Liu and Petrie, 1984).

Aid to Families with Dependent Children

The Medicaid program primarily serves children and mothers who receive Aid to Families with Dependent Children (AFDC), and those peope who are over age 65, blind, or disabled in the Supplemental Security Income (SSI) program. The discussion of the Medicaid population throughout this article revolves about Medicaid recipients, that is, persons who received at least one service under the Medicaid program during the year; for the time period under discussion, no reliable data are available on the average annual number of Medicaid enrollees or eligible persons.

Since the Medicaid program began on July 1, 1966, the AFDC population has been the largest component of the program. In fiscal year 1984, of the 21.4 million persons who received services under the Medicaid program, 15.4 million (about 70 percent) were in the AFDC category. These AFDC Medicaid recipients included 9.8 million dependent children and 5.6 million adults in families with dependent children. As will be shown later, although the children and adults in the AFDC category represent nearly 70 percent of all Medicaid recipients, they account for only 25 percent of Medicaid expenditures.

The AFDC cash assistance program was established under Title IV of the Social Security Act in 1935. Federal grants reimburse a percentage of State expenses incurred in providing financial assistance to needy children and the needy relative with whom they are living. It is not enough to be a poor family with children to qualify for cash assistance under the AFDC program. Only certain categories of the poor qualify for cash benefits. To be eligible, a family with children must have income below a State-specified income standard, and the children must be deprived of parental support or care because of the death, incapacity, or continued absence of a parent. States have the option of providing AFDC grants to other groups, including two-parent poor families if the parent who is the principal earner is unemployed.

The Office of Family Assistance, Social Security Administration, periodically analyzes the demographic and economic characteristics of AFDC families. In 1975, the proportion of AFDC children deprived of parental support or care because of divorced and separated parents was at a peak level of 48 percent; children in families with unmarried mothers accounted for 31 percent. In 1982, as shown in Table 8, the leading reason that children on AFDC assistance were deprived of parental support was because their parents were unmarried; this accounted for 46.5 percent of all children receiving assistance. Children in families with

Table 8

AFDC[1] children receiving cash assistance, by reason for deprivation of support or care of parent: May 1982

Reason for deprivation	May 1982	
	Number in thousands	Percent
Total recipient children	6,624	100.0
Deprived because father is:		
Deceased	58	0.8
Incapacitated	229	3.5
Unemployed	399	6.0
Absent from home:		
In Armed forces	2	0.0
Divorced/legally separated	1,363	20.6
Nonlegally separated (deserted)	1,260	19.0
Not married to mother	3,080	46.5
Other reason	103	1.5
Deprived because mother is not at home	85	1.3
Reason for deprivation is not known	45	0.7

[1] Aid to Families With Dependent Children.

SOURCE: (Social Security Administration, 1985).

divorced and separated parents accounted for 39.6 percent. It is clear that an out-of-wedlock birth places a child at high risk of being poor. In 1980, there were 666,000 out-of-wedlock births nationwide. Of these births, 55 percent (366,000 children) were included in the May 1981 AFDC case load (Social Security Administration, 1985).

The AFDC family size has been decreasing. In 1967, the average size of an AFDC family was 4.1 persons; in 1982, the average size was 2.9 persons. In 1982, nearly 75 percent of AFDC famililies had one or two children; only 10 percent of the families had more than three children (Social Security Administration, 1985).

The Omnibus Budget Reconciliation Act (OBRA) of 1981 contained provisions that directly affected the size and composition of families covered under the AFDC program. The major OBRA provision required fuller consideration of other income, especially earned income, received by, or available to, AFDC families. OBRA provided that a family could not be eligible for AFDC if it had total income exceeding 150 percent of the State's need standard.[2] In response, 16 States raised their need standards, evidently to curtail cuts in eligibility for AFDC cash assistance (Hill, 1984).

OBRA had a major initial impact on the AFDC population. Comparison of data before and after implementation of OBRA shows that, in May 1981, an estimated 11.8 percent of AFDC families had earned income; in May 1982, only 5.7 percent had earned income, representing a decrease of about 242,000 cases. The total number of children qualifying for AFDC grants fell from 7.3 million in May 1981 to 6.6 million in May 1982. In May 1983, AFDC grants to children rose to 7.1 million, the rise attributed primarily to an increase in the number of grants to children in families with unemployed parents. In May 1984, the figure rose again to 7.2 million children Office of Family Assistance, 1985).

Medicaid eligibility policy for all categories of assistance is extremely complex, because it is governed by both the rules and regulations of separate State public assistance programs and Federal Medicaid laws and regulations. As noted, the AFDC assistance program provides grants primarily to poor families with children who are deprived of parental support because of death, incapacity, or continued absence. At a minimum, each State's Medicaid program must cover all persons who receive cash payments under the AFDC assistance program. Large variations exist, however, in how each State runs its AFDC cash assistance program, which in turn determines who is automatically eligible for Medicaid. States may also provide cash benefits to specified optional groups. If States include any optional groups in their AFDC cash assistance program, then they must automatically include them in their Medicaid program. In 1982, 23 States optionally covered families with unemployed parents, 29 States covered first-time pregnant women, and 37 States covered 18-year-old children who are attending school (Clinkscale et al., 1983; Hill, 1984), as well as other optionally specified groups.

State Medicaid programs may also cover the "medically needy"; these are categorically related individuals ineligible for cash assistance whose income is no greater than 133⅓ percent of the payment level the State sets for an AFDC family of the same size. By including a "spend-down" provision, a State opens up Medicaid to categorically related people of any income level, if their medical bills are large enough. It is possible for a family to have income above the AFDC cash assistance standard but below 133⅓ percent of that level, thus automatically qualifying for medically needy benefits. However, in many cases, medically needy families have incomes in excess of the medically needy income level, but they "spend down" to that protected income level (Hill, 1984). Spend down refers to the process whereby people incur medical expenditures which, when deducted from their incomes, reduce their incomes down to the State's medically needy income level. In 1982, 29 States and the District of Columbia had a medically needy program; 20 States did not have one.

Other needy children are also optionally included in State Medicaid programs. One coverage group that is potentially large is often referred to as "Ribicoff kids," so named because Senator Abraham Ribicoff sponsored the portion of the Medicaid legislation establishing this optional Medicaid group. These poor children come from intact, two-parent families, or are institutionalized, in foster homes, or have their adoptions subsidized by a public agency (Hill, 1984). States may cover some or all of these children. Rymer, Burwell, and Madigan (1984) have estimated that, in 1982, this group was less than 4 percent of all Medicaid recipients; however, the average cost per recipient was about twice as much as for the average AFDC child, probably indicating that only those with substantial medical needs are enrolled under the Ribicoff provision.

---

[2] Determination as to whether or not a family is eligible for an AFDC cash assistance grant begins with listing total family income. Under State rules, a portion of total income may be "disregarded" for costs of transportation to the job, child care, and so forth. OBRA limited the sum of all income disregarded to 50 percent of the State's need standard.

Supplemental Security Income

The Medicaid program provides coverage for persons who receive cash benefits under the Supplemental Security Income (SSI) program and other SSI-related persons who meet financial criteria. In 1984, more than 6 million people in the SSI categories received Medicaid benefits. The SSI categories include three groups: aged persons 65 years or over, blind persons, and disabled persons. Although the SSI categories make up less than 30 percent of Medicaid recipients, these individuals account for more than 70 percent of Medicaid outlays.

To qualify for SSI payments, a person must satisfy income and resource tests as well as program criteria for either aged, blind, or disability status. The criteria for the aged group is that a person must be 65 years or over, for blindness and disability, the criteria are essentially the same as the social security disability criteria. The Federal Government sets a uniform national payment level that may be supplemented by the States.

The Office of Policy, Social Security Administration, periodically reports on the characteristics of the SSI population. In December 1983, more than 3.9 million people received SSI cash benefits. In the aged category, there were 1.5 million people; in the blind category, 79,000 people; and in the disabled category, 2.3 million people. Among the blind, 23,000 people were aged; among the disabled, 465,000 people were aged. Thus, nearly 2 million of the SSI cash recipients were 65 years of age or over. Black people and females are disproportionately represented in the SSI population. Approximately 60 percent of the SSI cash recipients were white and 26 percent were black. People of other races made up 4 percent; for the remainder, race was unknown. Of all aged SSI recipients, 74 percent were female; of the blind and disabled SSI population, 60 percent were female. Disabled children represented about 6 percent of the SSI caseload; the majority of child recipients were 14 years of age or under (Kahn and Rasberry, 1984).

By Federal law, States do not have to automatically cover all SSI cash recipients in their Medicaid programs. States have three options. First, they can elect to automatically cover all SSI recipients under Medicaid; in 1982, 28 States and the District of Columbia elected this option. Second, States can elect to cover all SSI cash recipients if the SSI individuals complete a separate Medicaid application to the States; in 1982, six States elected this option. Finally, States may impose Medicaid eligibility criteria that are more restrictive than the Federal SSI criteria so long as the criteria were part of the State's Medicaid State plan in January 1972; in 1982, there were 15 States that had elected this option (Rymer, Burwell, and Madigan, 1984). In the 29 States and the District of Columbia with medically needy programs, Medicaid is opened up to categorically related aged, blind, and disabled persons who can qualify as medically needy.

Medicaid recipients

In examining trends in the size of the Medicaid population, it is necessary to emphasize that data are not available on the number of persons enrolled each year in the Medicaid program. Federal reporting requirements for States up until recently have focused on obtaining counts of "recipients," that is, the number of persons who received Medicaid covered services. Because not all Medicaid enrollees use a service in any 1 year, the number of Medicaid recipients is clearly an undercount of the number of Medicaid enrollees, that is, persons who are entitled to use services. For the period 1980-82, data are available from five large States that provide counts of enrollees and counts of recipients. In these five States, 75-81 percent of enrollees used services in a given year. Thus, the use of counts of total recipients as a proxy for the number of enrollees in these States would have underestimated total enrollees by about 20-25 percent. For AFDC children, recipient counts would underestimate enrollee counts by 20-30 percent; for AFDC adults, by 20-25 percent; and for the Medicaid aged, blind, and disabled, by 10-25 percent (Baugh, 1985). Despite such shortcomings in using recipient counts, recipient data are useful for examining population trends over time and for use and expenditure analyses, which are covered in this article.

The number of Medicaid recipients, by eligibility categories, between 1973 and 1984, are shown in Table 9. Although the total number of Medicaid recipients increased from 19.6 million in 1973 to 21.4 million in 1984, or 8.9 percent, the number of recipients rose only until 1977, when the total reached 22.9 million. Between 1978 and 1984, the number of recipients moved up or down, but only by small amounts. The number of children in the AFDC category receiving Medicaid services increased 13.3 percent, but the number of adults increased 37.7 percent; the smaller increase for children reflects, in part, the decrease over time in the size of the AFDC family.

In 1984, Medicaid SSI recipients numbered just over 6 million people. Of these, 3.2 million were aged, 2.9 million were disabled, and 80,000 were blind. Between 1973 and 1984, the number of aged and blind Medicaid recipients declined. In contrast, the number of disabled rose 59 percent. The relatively large increase in the disabled under Medicaid parallels somewhat the large increase in the disabled under

Table 9

Medicaid recipients, by basis of eligibility: United States, selected fiscal year 1973-84

Basis of eligibility	1973	1976	1980	1983	1984	Percent increase 1973-84
	Number in thousands					
Total	19,622	22,815	21,605	21,554	21,365	8.9
Aid to Families with Dependent Children:						
Dependent children under age 21	8,624	9,924	9,333	9,535	9,771	13.3
Adults in families with dependent children	4,066	4,773	4,877	5,592	5,598	37.7
Supplemental Security Income:						
Age 65 or over	3,496	3,612	3,440	3,372	3,166	-9.4
Blind	101	97	92	77	80	-20.8
Disabled	1,804	2,572	2,819	2,844	2,870	59.1
Other Title XIX recipients	1,496	1,836	1,499	1,129	1,184	-20.9

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Medicaid Statistics Branch.

Medicare; in 1984, the Medicare disabled and the Medicaid disabled population each numbered about 2.9 million people, with about a 20-percent overlap.

The distribution of Medicaid recipients in 1984, according to whether they were categorically needy or medically needy, is shown in Table 10. Of all Medicaid recipients, States reported that 16.7 million people (74.4 percent) received cash assistance, 2.4 million (10.6 percent) were categorically needy but not receiving cash assistance, and 3.4 million (15.0 percent) were medically needy. Rymer, Burwell, and Madigan (1984) point out that such data must be viewed with caution because of differences in State practices regarding the classification of institutionalized Medicaid recipients as categorically needy versus medically needy. From these data, it appears that AFDC Medicaid recipients are much more likely to be receiving cash assistance. Of the AFDC Medicaid recipients in 1984, 85 percent of the dependent children and 81 percent of the adults in families with dependent children were reported to have received cash payments. The categorically needy group not receiving cash assistance consists primarily of families who have been terminated for AFDC cash assistance but who receive Medicaid benefits.

Many of the aged become Medicaid recipients for the first time while in nursing homes, because the Medicaid program plays a major role in the financing

Table 10

Medicaid recipients, by basis of eligibility: United States, fiscal year 1984

Basis of eligibility	All Medicaid recipients	Categorically needy: Receiving cash payments	Categorically needy: Not receiving cash payments	Medically needy
		Percent distribution		
Total	100.0	74.4	10.6	15.0
		Number in thousands		
Total	21,365	16,662	2,378	3,367
Aid to Families with Dependent Children:				
Dependent children under age 21	9,771	8,314	661	796
Adults in families with dependent children	5,598	4,517	467	614
Supplementary Security Income:				
Age 65 or over	3,166	1,719	667	780
Blind	80	70	5	5
Disabled	2,870	2,216	288	365
Other Title XIX recipients	1,184	0	307	878

NOTE: Columns and rows may not add to total because persons may be classified in different categories during the year.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Medicaid Statistics Branch.

of nursing home care. The 1980 U.S. Census found 4.6 percent of the aged (more than 1.2 million people) in homes for the aged, including nursing and convalescent homes. Today, the average annual cost of nursing home care exceeds $20,000 per year (Doty and Liu, 1985). Few of the aged have long-term care insurance or the financial resources to cover an extended nursing home stay. In 1984, Medicaid covered 43.4 percent of all nursing home care expenditures. It has been estimated that one-half of these Medicaid outlays were for aged persons who entered nursing homes as private-pay patients, but who exhausted their assets, becoming impoverished and dependent upon Medicaid.

Of the 3.2 million aged Medicaid recipients in 1984, 54 percent were reported to have received cash assistance; of the 80,000 blind and 2.9 million disabled Medicaid recipients, 88 percent and 77 percent, respectively, were reported to have received cash payments (Table 10).

As noted earlier, in addition to the discretion States have in opening up their Medicaid program to certain optional groups and to categorically related, medically needy persons, States have complete latitude for setting the AFDC need standards and payment levels, the basis for cash assistance and hence Medicaid eligibility for families with children. AFDC need standards are income levels set by the State to represent the minimum income that the State determines is necessary for families to subsist; payment standards are what the State actually uses in determining cash awards and are generally lower than the need levels that are set. In 1982, the monthly payment level in Alabama for an AFDC family of two was $89, the lowest in the Nation; in Alaska, the payment for an AFDC family of two was $508, the highest in the Nation. As shown in Table 11, the payment level for an AFDC family of two was lower in every State than the SSI payment level for an aged couple. For SSI aged couples, the Federal payment level was $397; 26 States and the District of Columbia chose to supplement the Federal payment level, with California, Colorado, Alaska, and Massachusetts raising the SSI income level to more than $600 per month.

The Congressional Budget Office studied the impact of requiring all States to set minimum AFDC benefits at a level sufficient to assure that any family would have cash income plus food stamps equal to at least 65 percent of the Federal poverty guidelines. If such a minimum were to be in effect in 1986, AFDC cash benefits would need to be raised for some or all current recipients in 41 States (Congressional Budget Office, 1985).

Medicare-Medicaid dual enrollees

A substantial proportion, more than 3 million people, or about 15 percent of the Medicare population 65 years of age or over, are also covered by the Medicaid program. More than half a million people, or about 21 percent of the Medicare population entitled because of disability, are also covered by Medicaid. From a different perspective, nearly all of the Medicaid aged have Medicare Part A entitlement (hospital insurance covers virtually the entire aged population) and an estimated 85 percent of the Medicaid aged have Part B (supplementary medical insurance) primarily through State buy-in agreements; about 20 percent of the Medicaid disabled have Medicare coverage. For these dual enrollees, Medicare is the first payer for those services covered by the Medicare program, and Medicaid is responsible for the Medicare cost-sharing provisions in the form of deductibles and coinsurance. For services that Medicare does not cover, such as drugs and long-term nursing home services, Medicaid has the primary responsibility.

The population dually entitled to both programs (sometimes called the "crossover" population) has been the focus of attention for some time because of the relatively high expenditure levels associated with this group. Because of this group, changes in either program are likely to have an impact on the other. If benefits or eligibility are curtailed under Medicaid, persons also entitled to Medicare may substitute covered Medicare services for those that would otherwise be paid by Medicaid. Similarly, increased cost sharing under Medicare will shift costs to Medicaid for the dually entitled.

The dually entitled aged population are of special interest, because a high proportion of the aged become dually entitled once they become medically needy as a result of requiring long-term nursing home services. Studies of the dually entitled aged population indicated that they were considerably older, with 36 percent of the group 80 years of age or over, compared with 20 percent of all other Medicare enrollees. More than 70 percent of the dually entitled were female, compared with 59 percent for all other Medicare enrollees; 24 percent were persons of races other than white, compared with 6 percent for all other Medicare enrollees without Medicaid entitlement. Morbidity and mortality rates were substantially higher for the dually entitled elderly, compared with all other Medicare enrollees, even when adjusting for age differences.

The elderly living in the community who received cash assistance and were enrolled in Medicare and Medicaid were also found to have poorer health status, much less formal education, and higher use of services than all other Medicare enrollees in the same age groups (McMillan et al., 1983; McMillan and Gornick, 1984). It is likely that for some of the elderly on cash assistance, lower health status in earlier years was a major cause of their lack of educational attainment which resulted in poverty in their old age. For others, the reverse is likely: poverty and low educational attainment in early and mid years have contributed to their higher morbidity and mortality in later years.

Table 11

Monthly payment and income levels of State Medicaid programs for two-person families: 1982

State	AFDC[1] payment standard two-person family	SSI[2] income level for aged couple	Medically needy income level two-person family	Ratio: Medicaid recipients to number in poverty (x100)
Alabama	$ 89	$397	(3)	44
Alaska	508	638	(3)	40
Arkansas	133	397	$158	50
California	408	815	475	110
Colorado	247	674	(3)	46
Connecticut	347	491	417	76
Delaware	197	397	(3)	65
District of Columbia	225	427	436	99
Florida	150	397	(3)	38
Georgia	161	397	(3)	46
Hawaii	390	421	400	101
Idaho	245	444	(3)	35
Illinois	250	467	250	75
Indiana	222	397	(3)	37
Iowa	292	397	(3)	60
Kansas	272	397	390	60
Kentucky	162	397	217	59
Louisiana	125	397	192	44
Maine	223	412	300	95
Maryland	211	397	284	70
Massachusetts	314	611	425	124
Michigan	330	433	434	83
Minnesota	368	441	368	80
Mississippi	188	397	(3)	48
Missouri	199	397	(3)	50
Montana	193	397	265	46
Nebraska	280	534	375	43
Nevada	194	487	(3)	35
New Hampshire	292	413	292	54
New Jersey	273	416	(3)	86
New Mexico	189	397	(3)	38
New York	356	476	483	86
North Carolina	167	397	225	43
North Dakota	270	397	385	38
Ohio	216	397	(3)	67
Oklahoma	218	555	292	61
Oregon	286	407	(3)	87
Pennsylvania	262	446	367	92
Rhode Island	368	485	425	120
South Carolina	102	397	(3)	66
South Dakota	280	412	(3)	31
Tennessee	97	397	133	44
Texas	122	397	(3)	32
Utah	278	417	371	35
Vermont	409	453	479	86
Virginia	203	397	268	51
Washington	339	433	434	70
West Virginia	164	397	225	43
Wisconsin	377	558	542	95
Wyoming	280	437	(3)	29

[1] Aid to Families with Dependent Children.

[2] Supplemental Security Income.

[3] No medically needy program.

NOTE: Recipients are those individuals both eligible for and actually receiving Medicaid services in fiscal year 1980. Because recipients are not necessarily in poverty and vice versa, the percentage reported is not the same as the percentage of people in poverty receiving program benefits.

SOURCES: (Rymer, Burwell, and Madigan, 1984; U.S. General Accounting Office, 1983).

Economic status of the aged

The Medicare and Medicaid programs were enacted to provide access to care for the most vulnerable population subgroups in the Nation. An understanding of the changes in the economic position of these groups is important in assessing future directions of the programs. First we examine the economic status of the aged, then we will address the economic status of children. The economic position of the elderly has risen considerably in recent decades. The trends in the major economic indicators show substantial overall gains. However, as in other age groups, a wide range exists in the economic status of the elderly, and sociodemographic variables are associated with that range.

In contrast to the near-universal eligibility to the Medicare program on the first day of implementation,

Table 12

Number of persons 65 years of age or over per 1,000 receiving social security benefits and Supplemental Security Income: United States, selected years 1940-83

Year	Social security beneficiaries[1]	Supplemental Security Income
	Number per 1,000 aged	
1940	7	217
1945	62	194
1950	164	224
1955	394	179
1960	616	141
1965	752	117
1970	855	104
1975	904	111
1980	914	87
1982	930	75
1983	935	73

[1] Old age survivors and disability insurance.

SOURCE: (Social Security Administration, 1984-85).

eligibility for monthly cash benefits under the social security retirement program came about in a much more gradual way. Social security was enacted in 1935, and monthly cash benefits were first paid in 1940. In that year, 7 out of 1,000 persons 65 years of age or over qualified to receive cash benefits (Table 12). By 1950, 164 out of 1,000 persons were receiving benefits. When Medicare was enacted, 75 percent of the aged were receiving social security retirement benefits. Unlike Medicare, however, which provides a uniform set of benefits to all enrollees, social security cash benefits vary, depending on the number of years in covered employment and the employees' earnings. Trends in the proportion of aged persons who received social security retirement benefits and the proportion of aged persons who received cash assistance from the Supplemental Security Income (SSI) program or earlier assistance programs, for the period 1940-83 are shown in Table 12. As the proportion of aged persons receiving social security rose, the proportion receiving welfare payments under SSI declined.

Although 75 percent of the aged were receiving social security retirement benefits in 1965, when the Medicare legislation was enacted, the aged as a group were in much poorer economic circumstances than the Nation as a whole. Measured by the official poverty index, based on the cost of a minimum but nutritionally adequate diet, 29 percent of the noninstitutionalized aged in 1966 were living in poverty, compared with 15 percent of the total population (Table 13). The relatively high level of poverty among the aged, their higher-than-average incidence of illness and disability, and their inadequate private health insurance coverage (which threatened financial ruin if they experienced a serious illness and hospitalization) were the compelling reasons for amending the Social Security Act to include health insurance coverage.

Between 1959 and 1969, the poverty level fell for the Nation as a whole (from 22 to 12 percent) and for the aged as a group (from 35 to 25 percent). After 1969, the poverty level for the aged continued downward, reaching the overall level for the Nation in 1982 (15 percent), and, in 1984, at 12 percent, measured 2 percentage points below the national average. The series of substantial increases in social security cash benefits enacted during the late 1960's up through 1974 (February 1968, 13 percent; January 1970, 15 percent; January 1971, 10 percent; September 1972, 20 percent; and June 1974, 11 percent), and the automatic cost-of-living adjustment to social security cash benefits, beginning January 1975, were clearly instrumental in reducing the poverty level among the aged. Although the proportion of the aged who were under the poverty level has improved dramatically, the absolute number of aged persons living in poverty (3.3 million people) was still substantial in 1984 because of the growth in the aged population (Table 13).

The role the social security program plays in the general economic position of the aged is reflected in Table 14, which shows the types of income received in 1983, whether from earnings, social security, supplemental security income, private pensions, or other programs or sources; and the distribution of income by type.

The data are categorized into family units consisting of an aged individual living alone or of multiperson families headed by a person 65 years of age or over,

Table 13

Number and percent poor of total persons all ages and persons 65 years of age or over: United States, selected years 1959–84

Year	Persons all ages			Persons 65 years or over		
	Total in millions	Poor in millions	Percent poor	Total in millions	Poor in millions	Percent poor
1959	177	39.5	22	16	5.5	35
1966	193	28.5	15	18	5.1	29
1969	200	24.3	12	19	4.8	25
1976	212	25.0	12	22	3.3	15
1980	225	29.3	13	25	3.9	16
1981	227	31.8	14	25	3.9	15
1982	229	34.4	15	26	3.8	15
1983	232	35.3	15	26	3.7	14
1984	234	33.7	14	27	3.3	12

SOURCE: (Social Security Administration, 1984-85).

Table 14
Shares of money income from earnings and other sources for aged families: 1983

Type of money income received during year	Aged family units					
	Individuals age 65 or over living alone or with nonrelatives only			Multiperson families with householder age 65 or over		
	Total	Nonpoor	Poor	Total	Nonpoor	Poor
	Number in millions					
Families and unrelated individuals	8.6	6.3	2.3	9.7	8.8	0.8
	Amount					
Mean household income	$10,037	$12,379	$3,528	$21,419	$23,013	$4,670
	Percent receiving income					
Earnings	13	16	6	43	45	20
Public program payments:						
Social security	92	94	86	94	94	87
Supplemental Security Income	11	4	30	6	5	23
Other public assistance	1	(1)	1	1	1	7
Other programs	6	6	7	10	10	11
Other sources:						
Dividends, interest, rent	68	79	36	76	80	35
Private pension, annuities, other	31	39	7	48	52	11
	Percent distribution of income					
Total	100	100	100	100	100	100
Earnings	10	11	1	28	28	3
Public program payments:						
Social security	44	41	77	34	33	73
Supplemental Security Income	2	1	14	1	1	9
Other public assistance	(1)	(1)	(1)	(1)	(1)	4
Other programs	1	1	2	1	1	4
Other sources:						
Dividends, interest, rent	29	31	4	21	21	4
Private pension, annuities, other	14	15	2	15	15	4

[1] Less than 0.05 percent

SOURCE: (Social Security Administration, 1984-85).

and divided into "nonpoor" and "poor" units. In 1983, the poverty threshold for the aged was $4,775 for individuals and $6,023 for two-person families (U.S. Bureau of the Census, 1985).

In households consisting of one aged individual, 92 percent received social security cash benefits and 11 percent received SSI; in multiperson families headed by an aged person, 94 percent received social security cash benefits and 6 percent received SSI. The lower bank of figures shows that social security accounted for 44 percent of total income for individuals and 34 percent for multiperson units.

In poorer family units consisting of one individual, social security was the predominant source of income, accounting for 77 percent of total income. For these individuals, social security benefits provided, on average $2,717 of the $3,528 total income; supplemental security income added a small amount, accounting for 14 percent of the income of poor individuals or, on average, $494 of total income.

After social security, the next most important source of income for nonpoor aged individuals was from capital investments, that is, dividends, interest, and rents (31 percent); for nonpoor multiperson units, it was from earnings (28 percent). Private pensions and annuities accounted for only 15 percent of total income for nonpoor family units. For poor family units, income from private pensions was virtually nonexistent, accounting for 2-4 percent of total income.

These data suggest that certain sociodemographic factors are associated with the economic status of the elderly. Among aged persons living alone, 2.3 million of the 8.6 million people (27 percent) were living in poverty, whereas only 0.8 million (8 percent) of the 9.7 million multiperson units were poor. Vital statistics for the United States show that women currently outlive men by about 7 years; hence, women are much more likely than men to spend some of their final years living alone and living in poverty. Using the same source, the Social Security Administration (1984-85) developed further breakdowns by sex and race that show 43 percent of all aged women live alone, compared with only 17 percent of men. Women make up 59 percent of the general population, but they account for 71 percent of the total living in poverty (3.7 million aged).

The economic position of the aged is also associated with race. In 1983, of all aged black people living alone (0.8 million), 50 percent were living in poverty; of all aged white people living alone (7.8 million), 23 percent were living at or below the poverty level (Social Security Administration, 1984-85).

As noted earlier, the population 65 years of age or over spans a range of some 30-35 years. Age itself plays a role in the economic status of the elderly. For men and women, married or nonmarried, there is a substantial drop in income as age increases. In 1982, the median income for all aged married couples was $15,130; for the youngest group, couples 65-67 years of age, the median income was $17,930; for couples 80 years of age or over, the median income was only $11,070. For nonmarried aged persons, the corresponding figures were $5,880 for the total, $6,920 for those 65-67 years of age, and $5,360 for those 80 years of age or over (Grad, 1984). The relatively favorable economic status of the younger elderly is related to a variety of factors, including higher social security benefits and greater likelihood of private pensions. Additionally, because they have been in retirement a relatively short time, the likelihood of drawing down their assets is much lower than it would be for people who are 80 years of age or over.

No one social indicator provides full insight into the status of population subgroups. The poverty index was originally developed to conform to the annual March Current Population Survey sample of the U.S. Bureau of the Census which collected data only on cash or money income. Therefore, the index is a measure of money income only. Nonmoney income is not currently considered in calculating the poverty thresholds and hence does not reflect the fact that many families receive part of their income in kind, in the form of nonmoney transfers such as food stamps, subsidized housing, and health benefits. Beginning in March 1980, the Census Bureau began supplementing data on annual family money income with information on the number receiving certain selected noncash benefits; they are examining procedures for assigning a money value to each benefit.

The poverty index as a measure of income adequacy for the elderly also has other shortcomings, because the aged often do not have the same kinds of obligations as younger persons and, although not counted as income, most older Americans (including 65 percent of the elderly poor) own their homes and live there until they die. Their homes embody their independence and symbolize a lifetime of labor and family living. Public policy analysts and researchers have been looking for acceptable ways to "unlock" these assets so that the elderly can remain in their homes as long as they live, but can also use some of their home equity to add to their income to support improved nutrition, personal care needs, or any other uses that could enhance the quality of their lives (Scholen, 1984; Jacobs and Weissert, 1984; Weinrobe, 1984).

A final point about the economic status of the elderly involves the growing trend of early retirement. Data on early retirement from the Social Security Administration (SSA) indicate that, in 1982, of the total 1.6 million new awards made to retired workers 62 years of age or over, 1.2 million (74 percent) were reduced because they were made to workers between 62 and 65 years of age. Thus, three-fourths of the aged apply for retirement benefits before age 65. Of the new awards made to retired workers, 39 percent were for persons 62 years of age (Social Security Administration, 1983).

Although these early retirees are eligible for social security cash benefits, they do not qualify for Medicare until age 65. Therefore, there is a potential gap in health insurance coverage between retirement and age 65 for this group. This problem is further complicated by the fact that many early retirees retire because of poor health. An SSA survey in 1981 of newly retired workers indicates that, in general, individuals who first receive social security retired-worker benefits view themselves as being in good health. However, 32 percent indicated that they can no longer work, or they could work only part time or occasionally. Beneficiaries whose first monthly benefits were claimed at age 62 were more likely to report themselves in poor health than those receiving a first benefit at age 63 or over. Among those newly retired workers 62 years of age, about two-fifths reported they could not work any longer or could work only part time or occasionally (Packard, 1985). Thus, the poor health of many early retirees may make it difficult to obtain adequate health insurance coverage.

Economic status of children

The number of children in the Nation living at or below the poverty level, for selected years between 1959 and 1984, is shown in Table 15. In 1959, there were 64.0 million children under age 18. Of the total, 17.2 million children (27 percent) were at or below the poverty level. In 1969, the number and percent of children living in poverty fell, reaching 9.8 million (14 percent). Between 1969 and 1983, the number and percent of children living in poverty increased, with the figure in 1983 reaching 13.3 million (22 percent). These children constituted nearly 40 percent of all poor people, and they and the adults with whom they lived represented more than two-thirds of the poverty population in the Nation (Congressional Budget Office, 1985). In 1984, poverty figures for children declined, the number falling to 12.9 million or 21 percent of the total.

Female-headed households are highly correlated with poverty. In 1984, about one out of five children under age 18 lived in female-headed households. Of the children living in these households, 54 percent were living at or below the poverty level, more than four times the rate in male-headed households.

Race and ethnicity are also highly correlated with poverty. In 1983, 47 percent of all black children and 38 percent of all Hispanic children under 18 years of age were poor, compared with 15 percent of all nonminority children. Among minority children in female-headed households, about 7 out of 10 were poor (Congressional Budget Office, 1985).

Table 15
Number of children under 18 years of age and number and percent poor, by family head: United States, selected years 1959-84

	Number of children under 18 years in millions			Number poor in millions			Percent poor		
		Family head			Family head			Family head	
Year	Total	Male	Female	Total	Male	Female	Total	Male	Female
1959	64.0	58.3	5.7	17.2	13.1	4.1	27	22	72
1966	69.9	62.7	7.2	12.1	7.9	4.2	17	13	58
1969	69.8	61.7	8.1	9.8	5.4	4.4	14	9	54
1976	63.7	53.0	10.7	10.1	4.5	5.6	16	9	52
1980	62.2	50.6	11.5	11.1	5.2	5.9	18	10	51
1981	61.7	49.7	12.0	12.1	5.8	6.3	20	12	52
1982	61.6	49.6	11.9	13.1	6.4	6.7	21	13	56
1983	61.4	49.3	12.1	13.3	6.6	6.7	22	13	55
1984	61.7	49.2	12.5	12.9	6.2	6.7	21	13	54

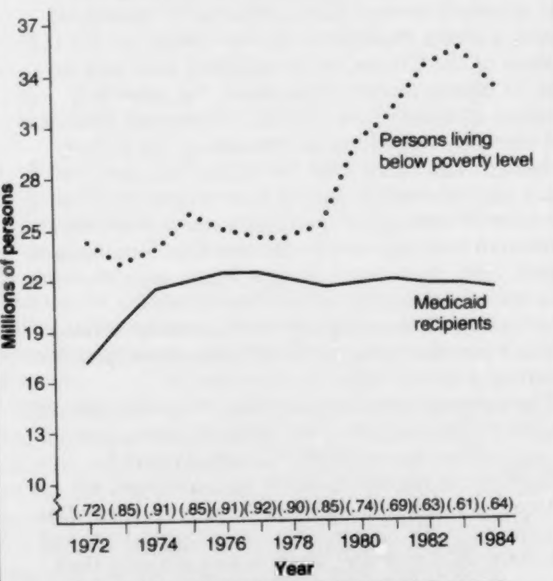
SOURCE: (Social Security Administration, 1984-85).

A rough gauge of the extent to which Medicaid covers the poverty population of all ages is the comparison between the number of Medicaid recipients and the number of persons below the poverty level. These measures are shown for the period 1972-84 (Figure 1). The gap between these two measures has been widening since 1978. The ratio of these two numbers reached a peak in 1977 (.92) and then began to decline. The ratio of these two measures for each State is given in Table 11.

The 1980 National Medical Care Utilization and Expenditure Survey (NMCUES) of the noninstitutionalized population collected information about the insurance status of the U.S. population by income level and by age. NMCUES data indicate that there were 25 million people in 1980 living at or below the poverty level. Of these, 49 percent were covered by Medicaid, 36 percent were not covered by Medicaid but were otherwise insured, and 15 percent were not insured. Of the poor under 19 years of age, 59 percent were covered by Medicaid, 28 percent were not covered by Medicaid but were otherwise insured, and 13 percent were uninsured (Kasper, 1985). In these figures, "coverage" by Medicaid or other insurance means that the individual was covered all or part of the year by Medicaid or other insurance. The 1977 National Medical Care Expenditure Survey (NMCES) found that, of persons "covered" by Medicaid, 43 percent were covered only part of the year; of those covered only part of the year, 64 percent were uninsured in the months they were not covered by Medicaid (Walden, Wilensky, and Kasper, 1985). Thus, the 1980 NMCUES estimate of the extent of Medicaid coverage should be viewed with the understanding that a substantial number of these individuals may be uninsured for part of the year.

Beginning in 1980, an ongoing gauge of the extent of Medicaid coverage of the poverty population became available when the March Current Population Survey (CPS) began to collect information about Medicaid coverage in the previous year for persons below the poverty level. The Survey found that in 1980, of the 28.4 million persons below the poverty level, 11.1 million (39.1 percent) had Medicaid coverage sometime during the year. In 1981, the figure was 37.8 percent, and, in 1982, 37.9 percent. Data for 1983, the latest available, indicate that of the total population living below the poverty level, 38.7 percent had Medicaid coverage sometime during the year. Thus, since 1980, estimates from the CPS on the proportion of the poor with Medicaid coverage sometime during the year ranged between 37.8 and 39.1 percent (U.S. Bureau of the Census, 1985).

Figure 1
Number of Medicaid recipients and number of persons below poverty level: United States, 1972-84



NOTE: The ratio of Medicaid recipients to persons below poverty level is given in parentheses above each year.

SOURCES: Health Care Financing Administration, Office of the Actuary: Data from the Medicaid Statistics Branch; (Social Security Administration, 1984-85).

Table 16

Aged beneficiaries use of Medicare hospital insurance benefits, by age, sex, and race: 1967 and 1983

Age, sex, and race	Persons served per 1,000 enrollees						Percent change		
	1967			1983			1967-83		
	Hospital	Skilled nursing facility	Home health agency	Hospital	Skilled nursing facility	Home health agency	Hospital	Skilled nursing facility	Home health agency
Total	185	18	7	242	10	46	31	–47	608
Age									
65-69 years	149	6	4	184	3	21	24	–59	486
70-74 years	171	11	6	223	5	35	31	–52	524
75-79 years	206	22	8	267	10	55	29	–54	572
80-84 years	240	40	11	312	18	78	30	–54	630
85 years or over	275	61	12	344	32	98	25	–48	691
Sex									
Male	198	15	5	251	7	40	27	–51	641
Female	175	20	7	235	11	50	34	–45	586
Race									
White	189	19	7	244	10	45	30	–47	594
All other	138	7	5	220	7	57	59	–2	983

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System.

Use of services

The following discussion provides a broad overview of the use of program services by beneficiary characteristics, including trends in the use of the Medicare hospital insurance and supplementary insurance benefits, use of services by the ESRD population, and use of Medicaid benefits.

Medicare hospital insurance benefits

The use of hospital insurance (Part A) benefits by aged Medicare beneficiaries for 1967 and 1983 are shown in Table 16. The primary Part A benefit is inpatient hospital care. The initial impact of Medicare was greater utilization of short-stay hospitals by the aged. During Medicare's first year, the number of hospital stays and the average length of stay for the aged increased 4-8 percent over the previous year (Pettengill, 1972); however, there had been a general upward trend in hospital use by the aged since 1950. In 1967, the first full year of Medicare coverage, 185 persons per 1,000 enrollees were hospitalized at least once. The user rate (defined as the number of persons per 1,000 enrollees with a reimbursed service) increased directly with age, from 149 persons per 1,000 enrollees 65-69 years of age to 275 persons per 1,000 enrollees 85 years of age or over. Traditionally, age has also had a significant impact on average length of stay, with the duration of the hospital stay for the oldest age group approximately 2-3 days longer than for the youngest age group. Since 1967, there has been a steady increase in the rate of hospitalization; by 1983, the rate was 31 percent higher, with 242 persons hospitalized per 1,000 aged enrollees. Although a small part of the overall increase can be attributed to the gradual aging of the population, the hospitalization rate increased across all age, sex, and race groups (Table 16). The difference in the hospitalization rates between males and females, and between white people and all other races, narrowed during these years.

In addition to the increase in the percent of persons hospitalized, an increase has occurred in the number of multiple hospitalizations (Lubitz and Deacon, 1982). In 1967, there were an average of 1.38 hospitalizations per person hospitalized. By 1977, this figure had risen to 1.48. As a result, the discharge rate (total discharges per 1,000 enrollees) increased even faster than the percent of persons hospitalized. In 1967, there were 268 discharges per 1,000 enrollees; about one-third of the discharges were surgical cases and two-thirds were medical cases. By 1983, the discharge rate increased 42 percent, to 381 discharges per 1,000 (Table 17). The rise in the discharge rate reflected a rise in the rate of both surgical and medical cases.

Although the discharge rate has shown a steady increase since Medicare's inception, the average length of stay for nearly all types of conditions decreased at a proportional rate, declining from a high of 13.5 days in 1969 to 9.6 days in 1983. Consequently, total days of care per 1,000 enrollees have remained at relatively the same level (3,500-3,950 days per 1,000 enrollees).

During this same time period, the hospital discharge rate also increased for the non-Medicare population 45-64 years of age, although the rate of increase was less than for the aged. Length of stay for the general population also declined (Lubitz and Deacon, 1982).

Use of hospital services by the Medicare population is a major factor in the hospital sector. In 1983, the

Table 17

Aged beneficiaries use of Medicare inpatient hospital and skilled nursing facility services: 1967-83

		Short-stay hospital					Skilled nursing facility	
Year	Number of Part A aged enrollees in millions July 1	Number of discharges in millions	Number of days of care in millions	Average length of stay in days	Number of discharges per 1,000 enrollees	Number of days of care per 1,000 enrollees	Number of days of care in millions	Number of days of care per 1,000 enrollees
1967	19.5	5.2	68.5	13.1	268	3,513	—	—
1968	19.8	5.6	75.6	13.4	285	3,823	—	—
1969	20.0	5.9	79.0	13.5	292	3,947	17.6	878
1970	20.4	6.0	77.4	13.0	292	3,800	10.7	525
1971	20.7	6.1	76.1	12.5	294	3,670	7.5	361
1972	21.1	6.4	77.2	12.1	302	3,656	6.6	314
1973	21.6	6.8	79.0	11.7	313	3,661	8.5	395
1974	22.0	7.0	80.9	11.5	320	3,677	8.7	395
1975	22.5	7.3	81.6	11.2	324	3,631	8.6	382
1976	22.9	7.6	84.4	11.1	332	3,684	9.4	410
1977	23.5	7.9	87.0	11.0	334	3,705	9.3	396
1978	24.0	8.1	88.6	10.8	339	3,692	8.6	360
1979	24.5	8.5	91.2	10.7	345	3,717	8.0	328
1980	25.1	9.1	96.8	10.8	361	3,855	8.0	318
1981	25.6	9.4	98.2	10.4	367	3,838	8.3	323
1982	26.1	9.8	100.4	10.2	376	3,846	8.4	322
1983	26.7	10.2	99.7	9.6	381	3,740	8.8	329

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System.

Medicare population (aged and disabled combined) accounted for 12 percent of the total U.S. population, yet accounted for 31 percent of hospital admissions and 41 percent of total days of care (Fitzmaurice, 1985). Therefore, Medicare practices and policies clearly have a major impact on the hospital system.

Increasing rates of hospitalization could be indicative of better access to health care for the aged. However, higher rates are not necessarily known to be optimal use rates. Because of this, considerable attention has been focused on the wide regional variations in Medicare hospital use. Across census regions and within small areas as well, large differences have persisted over time in hospital discharge rates, average lengths of stay, and annual Medicare reimbursements per enrollee for inpatient hospital care; these variations cannot be explained by differences in age, sex, or race of the residents in the areas (Gornick, 1982). The primary cause of these differences in practice patterns has been attributed to "professional uncertainty" about the optimal or appropriate use of certain medical and surgical procedures (Wennberg, Barnes, and Subkoff, 1982).

To encourage cost-effective use of inpatient hospital care, the Part A program was designed to include skilled nursing facility (SNF) and home health agency (HHA) services. The criterion for SNF coverage under Medicare is the medical necessity for the patient to receive post-hospital skilled nursing, convalescent, and rehabilitative services for restoration to maximum functional capacity.

Use of the SNF benefit is limited to persons with at least a 3-day hospitalization and must begin within 30 days of discharge (14 days was the requirement prior to 1981). The use rate of SNF's over time is shown in Table 16. In 1967, 18 persons per 1,000 enrollees had at least one Medicare covered SNF stay. Females had higher use rates than males, and white people had higher use rates than all other races. Use of the SNF benefit increases sharply with age; persons 85 years of age or over are 10 times more likely to have an SNF stay than those 65-69 years of age. Since 1967, the use of the SNF benefit under Medicare has almost halved (10 per 1,000 in 1983). The decrease has been consistent across age and sex groups. However, SNF use among all races other than white has remained unchanged. The decline in the use of the SNF benefit has been attributed to a more stringent application of the medical necessity criterion. When Medicare was first implemented, about 1 out of 16 hospital stays was followed by a Medicare covered SNF admission. By the early 1980s, only 1 out of 30 hospitalizations resulted in a Medicare covered SNF admission.

In terms of SNF days per 1,000 enrollees, the decrease has been even larger (Table 17). In 1969, Medicare aged persons used 878 covered days per 1,000 enrollees, but in 1983, they used only 329 days per 1,000 enrollees. Although Medicare covers up to 100 days in an SNF per episode of illness, the average number of covered days per user was only about 30 days.

Use of HHA care is also shown in Table 16. In 1967, 7 persons per 1,000 used this benefit under the Part A program. By 1983, the rate had risen to 46 per 1,000, a 608-percent increase. Part of this increase can be attributed to the fact that HHA services were available under the Part A and Part B programs until the 1981 amendments, which eliminated the prior hospital stay requirement under Part A and made HHA services virtually a Part A benefit only. From 1982 on, HHA services were only covered under Part B for persons without Part A coverage. Still, much of

Table 18

Disabled beneficiaries use of Medicare hospital insurance benefits, by age, sex, and race: 1974 and 1983

Age, sex, and race	Persons served per 1,000 enrollees						Percent change 1974-83		
	1974			1983					
	Hospital	Skilled nursing facility	Home health agency	Hospital	Skilled nursing facility	Home health agency	Hospital	Skilled nursing facility	Home health agency
Total	206	4	8	250	3	31	21	–34	292
Age									
Under 35 years	138	1	3	191	1	14	39	–31	324
35-44 years	164	2	5	208	2	22	27	–11	360
45-54 years	197	3	7	254	2	27	29	–34	294
55-59 years	230	5	10	262	3	33	14	–39	247
60-64 years	239	6	11	281	4	43	18	–34	302
Sex									
Male	195	4	6	231	2	25	19	–37	298
Female	226	5	11	282	4	42	25	–34	283
Race									
White	212	4	8	251	3	30	18	–36	283
All other	172	3	8	244	2	36	42	–19	327

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System.

the increase occurred prior to the 1981 legislative changes. HHA use increases with age; persons 85 years of age or over are 4½ times more likely to use this service than persons 65-69 years of age. Also, females are more likely to use home health services than are males. In 1967, white people had higher use rates than did all races other than white. However, by 1983, this pattern had been reversed (45 users per 1,000 for white people and 57 users per 1,000 for all other races).

Part A utilization trends among the disabled have paralleled those of the aged. User rates for the disabled for the years 1974 and 1983 are shown in Table 18. As with the aged, the use of hospital inpatient care increased over the years, from 206 per 1,000 enrollees hospitalized in 1974 to 250 per 1,000 in 1983. In 1983, the overall rate for the disabled (250 per 1,000) was close to the rate for the aged (242 per 1,000).

Between 1974 and 1983, the discharge rate for the disabled rose at a rate of 4.0 percent per year. This was considerably faster than the 2.0 percent annual increase in the discharge rate among the aged during the same time. Both aged and disabled persons experienced similar rates of decline in average lengths of stay. The net result is that, although the days of care per 1,000 did not change much for the aged between 1974 and 1983, the rate for the disabled increased 22 percent from 3,446 days per 1,000 in 1974 to 4,206 days per 1,000 in 1983 (Table 19).

Use of the SNF benefit is even less common among the disabled than among the aged (Tables 16 and 18). In 1983, only 3 persons per 1,000 disabled enrollees received SNF benefits, compared with 10 per 1,000 among the aged. For those persons who did use services, the average number of reimbursed SNF days was approximately 30 days, similar to that received by aged SNF users.

Use of HHA services by the disabled has been increasing, as it has for the aged, but at a lesser rate. In 1974, the user rates for HHA services for the disabled was 8 per 1,000; in 1983, it was 31 per 1,000 for the disabled, compared with 46 per 1,000 for the aged.

Medicare supplementary medical insurance benefits

The supplementary medical insurance (Part B) benefit, although a voluntary part of the Medicare program which requires a monthly premium, has covered about 97 percent of the aged each year. National surveys of the noninstitutionalized population in the United States in 1958 and 1963 showed that 68 percent of aged persons saw a physician during a year. In 1970, the rate had risen to 76 percent and, by 1980, to 82 percent (Andersen, Lion, and Anderson, 1976; National Center for Health Statistics and Health Care Financing Administration, 1980). Even though the proportion of aged persons seeing a physician increased after Medicare, the average number of visits per person declined, continuing a generally downward trend from 1958, when aged persons averaged 7.4 visits per year. Visits per person declined to 6.8, 6.4, and 6.0 visits per person in the years 1963, 1970, and 1976, respectively. In 1980, however, the rate went up to 6.7.

The use of Part B benefits by the aged population for the years 1967 and 1983 are shown in Table 20.

Table 19

Disabled beneficiaries use of Medicare inpatient hospital and skilled nursing facility services: 1974-83

Year	Number of Part A disabled enrollees in millions July 1	Short-stay hospital: Number of discharges in millions	Number of days of care in millions	Average length of stay in days	Number of discharges per 1,000 enrollees	Number of days of care per 1,000 enrollees	Skilled nursing facility: Number of days of care in millions	Number of days of care per 1,000 enrollees
1974	1.9	.6	6.6	11.1	309	3,446	.3	144
1975	2.2	.7	7.7	10.7	330	3,544	.3	133
1976	2.4	.9	9.0	10.5	359	3,780	.3	132
1977	2.6	1.0	9.9	10.3	366	3,764	.3	128
1978	2.8	1.1	10.8	10.0	388	3,872	.3	113
1979	2.9	1.2	11.2	10.0	400	3,858	.3	108
1980	3.0	1.2	12.4	10.0	414	4,186	.3	106
1981	3.0	1.3	12.6	9.9	427	4,267	.3	101
1982	3.0	1.3	12.6	9.8	437	4,271	.3	98
1983	2.9	1.3	12.3	9.6	440	4,206	.3	101

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System.

Table 20

Aged beneficiaries use of Medicare supplementary medical insurance benefits, by age, sex, and race: 1967 and 1983

Age, sex, and race	1967 Physician services	1967 Outpatient services	1967 Home health agency	1983 Physician services	1983 Outpatient services	1983 Home health agency	Percent change 1967-83 Physician services	Percent change 1967-83 Outpatient services	Percent change 1967-83 Home health agency
Total	359	58	7	655	307	0.7	83	425	(1)
Age									
65-69 years	316	56	3	588	279	0.5	86	396	(1)
70-74 years	348	60	5	636	301	1.1	83	403	(1)
75-79 years	387	62	8	689	321	1.3	78	422	(1)
80-84 years	414	58	12	729	334	0.3	76	475	(1)
85 years or over	446	55	19	767	356	0.1	72	548	(1)
Sex									
Male	346	60	4	624	297	0.4	80	392	(1)
Female	368	57	8	675	313	1.0	83	450	(1)
Race									
White	367	58	7	661	305	0.6	80	430	(1)
All other	246	72	6	599	327	2.5	143	355	(1)

[1] Not applicable. Beginning 1982, the home health agency benefit was included under Part A except for Medicare enrollees with Part B only.

SOURCES: (Social Security Administration, 1971); Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System.

To qualify for Part B reimbursements, a beneficiary must first meet a deductible amount. The deductible was set at $50 in 1967 and raised to $60 in 1973 and to $75 in 1982. In 1967, although an estimated 75-80 percent of aged enrollees used physician services, only about 36 percent (359 persons per 1,000 enrollees) met the deductible and received Medicare reimbursements for physicians' services. The proportion receiving reimbursements rose with age, was higher for females than for males, and was substantially higher for white people than for all other races.

The user rate for physicians' services climbed steadily in the year following 1967. By 1983, the overall user rate was 655 per 1,000. Some of this increase can be attributed to the fact that the deductible was not indexed to inflation, thus making it easier as time went by to qualify for Medicare reimbursements. Over time, the increase in the user rate was similar across all age and sex groups. Growth in the use of physicians' services probably reflected the growth of hospitalization under Medicare as well. Claims data indicate that about 60 percent of Part B reimbursements for physician care are for services rendered to persons during hospital stays.

In 1967, as shown in Table 20, there were marked differences by race in the user rate for physicians' services. In the first year of the program, the user rate among white people (367 per 1,000) was 49 percent higher than among people of all other races (246 per 1,000). Davis (1975) found that in 1968, the second full year of the program, there were still wide disparities by race. Over time, however, the disparity in the user rate fell each year, from 49 percent higher for white people in 1967, to 23 percent higher in 1973, to 16 percent higher in 1976 (Ruther and Dobson, 1981). By 1983, the discrepancy in the rate for white people and all other races had decreased to 10 percent (661 per 1,000 and 599 per 1,000, respectively). Indepth studies of the use of health care services by demographic characteristics indicate that, overall, noteworthy decreases have occurred in disparities by race and by ethnicity since the inception of the Medicare and Medicaid programs (O'Brien, Rodgers, and Baugh, 1985; Long and Settle, 1984).

Similar to the wide variations found in Part A utilization and charges, year after year, Part B use and reimbursement rates have varied considerably by geographic area and by State (Gornick, Hackerman, and Newton, 1980). Geographic differences in reimbursements reflect, in part, the present Part B reimbursement mechanism, which is based on customary and prevailing charges in local areas.

In discussing the use of physicians' services under Medicare, it is important to note that under Part B, the physician decides whether or not to accept assignment of claims on a claim-by-claim basis. When assignment is accepted, the physician agrees to accept Medicare's allowed charge as full payment. Physicians' acceptance of assignment is of considerable importance in relieving the beneficiary of the burden of additional medical care costs. If physicians do not accept assignment, the beneficiary is responsible for the difference between the physician's charge and the Medicare allowed charge. In the early years of the Medicare program, the proportion of claims that were assigned was about 60 percent nationally. Beginning in 1971, the assignment rate began a slow and steady decline, reaching a low of about 50 percent in 1978. After 1978, the assignment rate began to slowly rise, reaching nearly 54 percent in 1983.

In 1984, the Deficit Reduction Act (DEFRA) established the concept of participating physicians, those who voluntarily agree to accept assignment for all services provided to Medicare beneficiaries for a year; the assignment rate jumped 5 percentage points to 59 percent in 1984 and reached 69 percent as of September 1985. It should be observed, however, that traditionally there have been extreme variations in assignment rates by State (Ferry et al., 1980). In 1982, 87 percent of physician charges were assigned in Rhode Island, whereas only 17 percent were assigned in South Dakota. In addition, assignment rates vary considerably by characteristics of the physician, the beneficiary, and the type of service rendered (Rice and McCall, 1983; Mitchell and Cromwell, 1981). Because of increases in the amount physicians' charges are reduced, an unassigned claim now has a much greater potential impact on the Medicare beneficiary than it did in earlier years of the program. In 1973, Medicare reduced physicians' charges by an average of 12.2 percent; in 1975, charges were reduced an average of 17.4 percent; in 1982, the percent reduction averaged 23.7 percent (McMillan, Lubitz, and Newton, 1985). Thus, on average, an unassigned claim now means that the beneficiary is responsible for about one-fourth of the physicians' charges in addition to the deductible and 20-percent coinsurance requirements.

The second major Part B benefit is outpatient services. Outpatient services include clinic, emergency room, and ancillary services in a hospital outpatient department and services in freestanding facilities. In 1967, the outpatient benefit was used relatively infrequently; 58 aged persons per 1,000 enrollees received payments for use of outpatient services under Part B (until April 1968, diagnostic outpatient services were covered under Part A). By 1983, the rate had increased, by a factor of five, to 307 per 1,000 enrollees, an average annual increase of more than 10 percent. In 1983, little difference existed in use rates by sex and race, and there was only a small increase by age.

It is important to stress that, except for physicians' services, a minority of the Medicare enrollees use Medicare benefits in any 1 year. As shown earlier, only 24 percent of beneficiaries are hospitalized in a year. Increasing age is a factor clearly related to increasing use of inpatient hospital, SNF, HHA, and physicians' services under Medicare. Studies of certain subgroups of the population shed additional light on the use of services under Medicare. Lubitz and Prihoda (1984) showed that the use of services rises greatly in the last year of life. Not unexpectedly, the probability of being hospitalized in the last year of life and in the next to the last year is much greater than the overall average. McMillan et al. (1983) and McMillan and Gornick (1984) showed that the aged population with dual enrollment in Medicare and Medicaid were also at much higher risk of being hospitalized, probably because of their poorer health status.

Use of Part B benefits by the disabled is shown in Table 21. As with the aged, use of physician services has been steadily rising, from 396 disabled persons per 1,000 enrollees in 1974 to 639 per 1,000 in 1983. For physicians' services, use rises with age, and is higher among females and white people, although the difference by race decreased over time.

An even faster increase in the use of outpatient services by the disabled has occurred. User rates increased from 170 persons per 1,000 enrollees in 1974 to 382 per 1,000 in 1983, an annual increase of 9.4 percent. In 1983, the rate of use of outpatient services by the disabled (382 per 1,000) was markedly higher than for aged persons (307 per 1,000).

Services used by ESRD population

Utilization rates for ESRD beneficiaries take on different meanings than for aged and disabled beneficiaries. The aged and disabled have about a

Table 21
Disabled beneficiaries use of Medicare supplementary medical insurance benefits, by age, sex, and race: 1974 and 1983

	Persons served per 1,000 enrollees					Percent change	
	1974			1983		1974-83	
Age, sex, and race	Physician services	Outpatient services	Home health agency	Physician services	Outpatient services	Physician services	Outpatient services
Total	396	170	5	639	382	61	125
Age							
Under 35 years	265	139	4	532	376	101	171
35-44 years	313	152	4	571	376	83	148
45-54 years	379	172	5	635	393	68	129
55-59 years	447	185	6	652	380	46	105
60-64 years	454	177	6	705	380	55	115
Sex							
Male	357	155	4	586	345	64	123
Female	463	196	8	728	442	57	125
Race							
White	409	166	5	644	373	58	124
All other	326	193	6	612	426	87	121

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System.

24-percent probability of being hospitalized and a 65-percent chance of exceeding the Part B deductible and receiving benefits. The fact of renal failure itself ensures that these individuals must receive renal dialysis or a kidney transplant, or they will die. Thus, virtually 100 percent of the ESRD population are users of Medicare benefits. Most ESRD beneficiaries receive dialysis treatment on a routine basis (two to three times a week); transplanted patients are large users in the year that the transplant occurs. Nevertheless, there have been significant changes in the volume and types of services used by ESRD patients.

In 1972, about 40 percent of all dialysis patients were dialyzing at home. This figure decreased rapidly after ESRD patients were covered under Medicare. By 1979, the proportion of home dialysis patients was only 9 percent. The decline in patients dialyzing at home is partly explained by the fact that Medicare coverage expanded the universe of patients considered appropriate for treatment. More older, poorer, and sicker patients were being treated than had been previously. Many of these patients were not considered to be good candidates for home hemodialysis. In addition, Medicare reimbursement regulations in effect at the beginning of the program (1973) did not cover the entire costs of home dialysis, thus biasing treatment decisions toward in-unit dialysis. This bias was removed with the Medicare ESRD Amendments of 1978. However, home dialysis has not returned to the pre-Medicare levels.

In 1979, a new dialysis treatment therapy was introduced, known as continuous ambulatory peritoneal dialysis (CAPD). This new form of dialysis gives the dialysis patient greater freedom of movement and comfort. As shown in Table 22, there has been a considerable change in dialysis patterns in the past 5 years. In-unit hemodialysis remains the predominant form of dialysis, although the percentage of in-unit dialysis patients dropped slightly from 83 percent in 1980 to 80 percent in 1984. Home hemodialysis has continued to decrease, from 9 percent in 1980 to 5 percent in 1984. Meanwhile, CAPD has increased from just 4 percent of the dialysis population in 1980 to 14 percent in 1984.

The other major treatment of ESRD is kidney transplantation. Since the beginning of Medicare coverage, the major constraint on this therapy has been the supply of cadaver kidneys for transplantation. Nevertheless, the number of transplants has grown substantially since 1974, rising from 3,190 transplants in 1974 to 6,968 transplants in 1984, reflecting an annual growth rate of 8.1 percent. However, in 1983 and 1984, the growth of transplants accelerated at a rapid pace (14.1 percent and 14.0 percent, respectively) as shown in Table 23.

One factor that should have a major impact on transplantation is the Food and Drug Administration approval in November 1983 of the drug cyclosporine as an immunosuppressant for transplantation. Cyclosporine significantly improves kidney graft survival for patients receiving a cadaveric transplant (Krakauer et al., 1985). In addition, cyclosporine use seems to reduce the need for clinically matching recipients with donor organs. This could greatly increase the number of people receiving cadaveric transplants. Some evidence suggests this may be taking place. Although transplants increased by 14 percent in 1984, the increase for cadaveric transplants was 21.6 percent; transplants from live related donors decreased by 5.1 percent. In addition, in 1984, the number of persons awaiting transplant increased by

Table 22

Percent distribution of Medicare end-stage renal disease patients, by type and site of dialysis: 1980-84

Type and site	1980	1981	1982	1983	1984
			Number of patients		
Total[1]	52,364	58,924	65,765	71,987	78,483
			Percent distribution		
Total	100	100	100	100	100
In-unit hemodialysis	83	81	80	79	80
Home hemodialysis	9	8	7	6	5
CAPD[2]	4	7	10	12	14
Other[3]	4	4	3	3	1

[1] Includes a small percentage of patients not covered by Medicare.

[2] 1984 count for continuous ambulatory peritoneal dialysis includes patients on continuous cycling peritoneal dialysis.

[3] Includes in-unit peritoneal, home peritoneal, and self training.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the ESRD Systems Branch.

Table 23

Number of kidney transplants and annual percent change under the Medicare program: United States, 1974-84

Year	Number of transplants	Annual percent change
1974	3,190	—
1975	3,730	16.9
1976	3,504	-6.1
1977	3,973	13.4
1978	3,949	-0.6
1979	4,271	8.2
1980	4,697	10.0
1981	4,885	4.0
1982	5,358	9.7
1983	6,112	14.1
1984	6,968	14.0

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the ESRD Systems Branch.

19.9 percent, the largest increase since 1980 (Health Care Financing Administration, 1985).

Cyclosporine is an expensive drug. Estimates are that ongoing use of the drug costs about $6,000 per year. Because Medicare does not cover drugs on an ambulatory basis, costs are currently borne out of pocket by the beneficiary unless the patient has Medicaid or private insurance coverage.

The type of treatment ESRD patients undergo has a significant impact on continued participation or return to work or school; preliminary data from a study under way on nondiabetic ESRD patients 19-55 years of age show that, for patients treated at centers by hemodialysis, 30 percent were working or attending school full- or part-time; for those on CAPD, the figure was 46 percent; for those transplanted patients with functioning grafts, the figure was 79 percent (Simmons, 1985).

Interesting changes have occurred among ESRD beneficiaries in terms of use of other medical care not directly related to transplantation or dialysis. Overall, about 70 percent of dialysis patients are hospitalized in any year, compared with about 24 percent for aged and disabled beneficiaries. However, the discharge rate per 1,000 and the average length of stay for ESRD beneficiaries has decreased markedly since 1974 (Eggers, 1984). Between 1974 and 1979, discharge rates decreased by 17 percent and average length of stay decreased by 23 percent, resulting in a 35-percent decrease in the total days of care. During the same time, days-of-care rates for the disabled increased 22 percent and the rate for the aged remained essentially unchanged. Nonetheless, the days-of-care rate for the ESRD beneficiaries is still approximately four times as great as for other Medicare beneficiaries, illustrating the extreme illness level of the ESRD population. Despite the continuing need for dialysis and the high levels of morbidity (as measured by hospitalization rates), dialysis patients maintain a positive view of their quality of life (Evans et al., 1985). Thus, it seems that persons with end-stage renal disease adapt quite well to their adverse life circumstances.

Medicaid benefits

The Medicaid program was also conceived as a way of increasing access to needed medical care services. In 1963, only 56 percent of persons from low-income families saw a physician during a year; the comparable figure for persons from high-income families was 71 percent (Andersen, Lion, and Anderson, 1976). By 1970, 65 percent of persons from poor families saw a physician, and the figure for persons from high-income families remained unchanged. Much of this increased access for the poor can probably be attributed to Medicaid. Since that time, the differential by income has essentially disappeared. In 1980, the percent of persons seeing a physician during a year from low-, middle-, and high-income families was 76, 75, and 75 percent,respectively (National Center for Health Statistics and Health Care Financing Administration, 1980).

In addition, the number of physician visits increased for poor persons after the enactment of

Medicaid. In 1963, persons under the poverty level averaged 4.4 visits, compared with 4.6 visits for persons from high-income families. By 1970, the number had increased to 4.9 for poor persons, but visits actually decreased for persons from high-income families to 3.6. In 1980, the differential remained, with persons from poor families averaging 4.6 visits and persons from high-income families averaging 3.9. However, Aday, Anderson, and Fleming (1980) point out that the need for medical care is much higher among the poor; if one controls for variation in need for care, then the poor receive somewhat less care than the nonpoor.

Hospital admissions also increased for the poor after the enactment of Medicaid (Andersen, Lion, and Anderson, 1976), particularly for children. In 1963, the poor 17 years of age or under averaged 5 hospital admissions per 100 persons. The rate of admissions rose to 11 in 1970. For poor persons 18-54 years of age, the change was from 20 per 100 in 1963 to 24 per 100 in 1970.

Statistics are not available for all States on the number of persons enrolled in Medicaid. Therefore, rates of utilization in terms of persons at risk cannot be calculated. However, States are required each year to report the number of unduplicated recipients by eligibility category and type of service, and statistics on the numbers of recipients indicate general utilization trends in the Medicaid program.

In the past 10 years, the total number of Medicaid recipients has remained essentially the same. In 1975, there were 22.0 million recipients; in 1984, there were 21.4 million, the lowest number during this time period. The greatest number of recipients was in 1977, with 22.8 million.

Services covered by Medicaid include hospital inpatient, physician, long-term care in both intermediate care facilities (ICF) and skilled nursing facilities (SNF), dental, outpatient, drugs, lab, X-ray, clinic, family planning, and other services. Despite the large number of services covered, a few of the services account for most of the program expenditures. Hospital inpatient, SNF, ICF, ICF/MR (intermediate care facilities for the mentally retarded), physician, outpatient, and drugs account for 87 percent of the entire Medicaid budget.

The number of recipients of these services for 1975 and 1984 are shown in Table 24. The number of Medicaid recipients of hospital care has risen only slightly, from 3.4 million to 3.6 million, a 5-percent increase. Recipients of SNF services have declined during the last decade, by 10 percent, while recipients of ICF services increased by 17 percent. Because of the different definitions States might use in determining that a long-term care bed is an SNF bed or an ICF bed, it is probably instructive to look at the sum of ICF and SNF recipients. Combining the two indicates that there were 1,312,000 recipients of ICF and SNF services in 1975 and 1,365,000 in 1985, an increase of only 4 percent.

The largest increase has come in the area of services for the mentally retarded in intermediate care facilities. Recipients of ICF/MR services doubled from 69,000 in 1975 to 139,000 in 1984. Although these recipients represent a small fraction of those receiving benefits from Medicaid, increases in their numbers have had a disproportionate effect on Medicaid expenditures because of their high cost.

Table 24

Medicaid: Number of Medicaid recipients and percent change, by type of service: Fiscal years 1975 and 1984

Type of service	Number in thousands 1975	Number in thousands 1984	Percent change 1975-84
Total	22,007	21,365	-3
Inpatient hospital	3,432	3,612	5
Nursing home			
Skilled nursing facility	630	565	-10
Intermediate care facility	682	800	17
Intermediate care facility for the mentally retarded	69	139	101
Physician	15,198	14,198	-7
Outpatient	7,437	9,761	31
Drugs	14,155	14,006	-1
Other	(1)	(1)	(1)

[1] Miscellaneous category.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Medicaid Statistics Branch.

Program expenditures

Following is an overview of expenditures for the Medicare and Medicaid programs and populations. The growth and changes in Medicare expenditures are examined, including total and per capita expenditures and patterns in the distribution of services. Medicaid expenditures are discussed in terms of type of service, category of assistance, and State budgets. The impact that these expenditures have had on the poor, the elderly, and all levels of government is also discussed, as well as the rising costs of medical care in the United States relative to other countries.

Trends in Medicare benefit payments

Total Medicare reimbursements and reimbursements for the hospital insurance (Part A) program and for the supplementary medical insurance (Part B) program for the period 1966-84 are shown in Table 25. Total Medicare payments grew from $4.6 billion in 1967, the first full year of the program, to $62.9 billion in 1984. The accelerated rise in outlays in 1974 and 1975 reflects, in part, outlays for the newly entitled disabled and ESRD beneficiaries. During the period 1967-84, the annual compound rate of growth was 16.6 percent for the total program, 16.1 percent for Part A, and 17.9 percent for Part B. In terms of the real rate of growth (correcting for the general rise in the Consumer Price Index), the annual compound rate of growth was 9.1 percent for the total program,

Table 25

Medicare benefit payments and annual percent change: 1966-84

Year	Total	Hospital insurance	Supplementary medical insurance	Annual percent change for total
		Amount in billions		
1966	$1.0	$0.9	$0.1	—
1967	4.6	3.4	1.2	346.5
1968	5.7	4.2	1.5	25.2
1969	6.6	4.7	1.9	15.9
1970	7.1	5.1	2.0	7.5
1971	7.9	5.8	2.1	10.8
1972	8.6	6.3	2.3	9.9
1973	9.6	7.1	2.5	10.9
1974	12.4	9.1	3.3	29.6
1975	15.6	11.3	4.3	25.5
1976	18.4	13.3	5.1	18.2
1977	21.8	15.7	6.0	18.2
1978	24.9	17.7	7.3	14.5
1979	29.3	20.6	8.7	17.6
1980	35.7	25.1	10.6	21.7
1981	43.5	30.3	13.1	21.7
1982	51.1	35.6	15.5	17.6
1983	57.4	39.3	18.1	12.4
1984	62.9	43.3	19.7	9.5
		Percent		
ACRG[1]	16.6	16.1	17.9	—
ACRRG[2]	9.1	8.6	10.3	—

SOURCE: Health Care Financing Administration, Office of the Actuary: 1985 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Supplementary Medical Insurance Trust Funds.

[1] Annual compound rate of growth 1967-84.

[2] Annual compound real rate of growth 1967-84, adjusted for changes in Consumer Price Index 1967-84.

Table 26

Distribution of Medicare hospital insurance and supplementary medical insurance reimbursements for aged and disabled beneficiaries, by type of service: 1967 and 1983

Type of service	1967		1983		Annual compound rate of growth in percent
	Amount in millions	Percent	Amount in millions	Percent	
Total	$4,239	100.0	$53,438	100.0	17.2
Inpatient hospital	2,659	62.7	34,519	64.6	17.4
Physicians and related services	1,224	28.9	13,661	25.6	16.3
Skilled nursing facility	274	6.5	428	0.8	2.8
Home health agency	43	1.0	1,388	2.6	24.1
Outpatient	38	0.9	3,442	6.4	32.5

NOTE: Figures do not include final settlements.

SOURCES: (Social Security Administration, 1971); Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System.

8.6 percent for Part A, and 10.3 for Part B. The annual rate of growth (not corrected for inflation) from 1983 to 1984 was 9.5 percent, a figure lower than it has been since 1970. From the program's inception, Part A expenditures have been substantially greater than Part B, although Part B outlays have been a growing proportion of total Medicare expenditures. In 1967, Part A represented 74 percent of benefit payments, and Part B represented 26 percent. In 1984, the corresponding figures were 69 and 31 percent.

Medicare benefit payments (aged, disabled, and ESRD enrollees combined) by type of service in 1967 and 1983 are shown in Table 26. Payments for inpatient services and physicians' and related services combined account for about 90 percent of all Medicare payments. As a percent of total Medicare payments, inpatient hospital payments in 1983 (64.6 percent) were slightly higher than in 1967; physicians' payments in 1983 (25.6 percent) were a little less than in 1967. About 60 percent of physicians' payments are for services to hospital inpatients. Thus, in 1983, nearly 80 percent of all Medicare payments were for services to hospitalized patients.

Understanding the factors contributing to the large growth in hospital expenditures is of considerable interest to policymakers. The Division of National Cost Estimates, Office of the Actuary, Health Care Financing Administration, periodically examines the factors accounting for growth in expenditures for community hospital inpatient care. The latest analysis, for the period 1973-83, partitions the increase into five factors: overall inflation (50.9 percent), population increases (6.7 percent); hospital input prices in excess of the general inflation (14.6 percent); increases in admissions per capita (4.4 percent); and increases in intensity per admission (23.4 percent) (Arnett et al., 1985).

SNF, HHA, and outpatient benefits have all shifted significantly as a percent of total Medicare benefit payments. SNF payments dropped sharply from 6.5 percent in 1967 to only 0.8 percent in 1983. HHA payments rose to 2.6 percent in 1983, from only 1.0 percent in 1967. Outpatient benefit payments, the fastest growing component of the Medicare program, rose from only 0.9 percent of Medicare benefit payments in 1967 to 6.4 percent in 1983. Outpatient reimbursements in 1983 include services in hospital outpatient departments (85 percent) and freestanding outpatient facilities (15 percent). A substantial proportion of the 1983 payments for outpatient services was for ESRD dialysis treatment. Of the $3.4 billion for outpatient services, $0.85 billion was for ESRD patients. Nonetheless, there was a significant increase in the number of other Medicare beneficiaries in 1983 using outpatient services compared with 1967.

Medicare program payments in 1983 on behalf of the elderly accounted for 87.4 percent of total reimbursements, and on behalf of the disabled and ESRD beneficiaries, 12.6 percent. Per capita reimbursements for aged and disabled enrollees in 1983 are summarized in Table 27. For aged persons,

Table 27

Medicare Part A and Part B per capita reimbursement for aged and disabled enrollees, by type of service and age, sex, and race: 1983

Age, sex, and race	Total	Part A Inpatient hospital	 Skilled nursing facility	 Home health agency	Part B Physicians and related services	 Outpatient	 Home health agency
Aged							
Total	$1,724	$1,142	$16	$47	$460	$94	$1
Age							
65-69 years	1,286	824	4	22	375	88	1
70-74 years	1,618	1,057	9	36	453	98	1
75-79 years	1,942	1,300	18	56	514	101	1
80-84 years	2,249	1,525	29	80	550	93	0
85 years or over	2,396	1,644	48	102	551	88	0
Sex							
Male	1,835	1,228	11	40	493	98	0
Female	1,649	1,085	18	52	439	91	1
Race							
White	1,721	1,135	16	45	466	89	1
All other	1,803	1,252	12	69	420	142	3
Disabled[1]							
Total	1,900	1,271	5	37	490	150	0
Age							
Under 35 years	1,502	1,013	2	20	329	181	0
35-44 years	1,600	1,064	3	29	392	165	0
45-54 years	1,888	1,256	4	33	496	161	0
55-59 years	1,989	1,326	5	39	531	143	0
60-64 years	2,134	1,435	8	47	563	129	0
Sex							
Male	1,725	1,164	4	28	446	137	0
Female	2,203	1,457	6	52	563	171	0
Race							
White	1,894	1,266	5	35	503	138	0
All other	1,944	1,307	4	43	434	210	0

[1] Excludes persons with end-stage renal disease.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System.

the average reimbursement for all services combined was $1,724. Average reimbursements increased directly with age. Persons 85 years of age or over had reimbursements 86 percent higher ($2,396) than persons 65-69 years of age ($1,286). Average reimbursements were higher for males than for females and for persons of all other races than for white people.

Inpatient hospital, SNF, and HHA reimbursements rise substantially with age. As age increased from 65-69 years to 85 years of age or over, per capita reimbursements doubled for hospital services, multiplied 12 times for SNF services, and multiplied nearly 5 times for HHA services.

For disabled persons (excluding persons with ESRD), the average reimbursement for all services combined was $1,900 in 1983, or 10 percent higher than for the aged. The disabled population includes three distinct subgroups: disabled workers, disabled widows and widowers, and adults disabled in childhood. Lubitz and Pine (1985) analyzed the use of services by the disabled population under Medicare and found that average reimbursements for disabled workers and disabled widows and widowers were relatively similar for the same age group, but per capita reimbursements for the group of adults disabled in childhood were only one-half to one-third of the other disabled groups.

The 82,000 ESRD beneficiaries in 1983 accounted for 0.3 percent of Medicare enrollees and for $1.9 billion in program costs, or 3.6 percent of the total $53.4 billion payments. Although ESRD beneficiaries have much higher utilization rates for most services than do other Medicare beneficiaries, it is the high cost of maintenance dialysis that accounts for most of the disproportionate ESRD costs. Outpatient payments for the ESRD program in 1983 were $849 million, or 25 percent of all Medicare outpatient expenditures. In contrast, inpatient hospital expenditures for ESRD beneficiaries in 1983 were $617 million, or 1.7 percent of all Medicare inpatient hospital expenditures.

Total Medicare expenditures for ESRD beneficiaries were eight times greater in 1983 ($1.9 billion) than in 1974 ($229 million). Most of this growth was the result of the increased number of ESRD beneficiaries. In 1974, there were 16,000 persons in the program; by 1983, there were 82,000 persons. Thus, while enrollment was increasing by an annual rate of 17.8 percent, the per capita costs were increasing by an annual rate of only 4.8 percent.

On a per capita basis, ESRD payments were approximately $14,300 in 1974 and $23,000 in 1983, or 62 percent greater. In comparison, Medicare per capita payments for the aged during this same time period grew from $455 to $1,724, or by 280 percent. The low increase in per capita costs for ESRD enrollees was, in large part, attributable to the maximum dialysis charge that was set at $138 in 1973 and remained unchanged until August 1983. At that time, the maximum charge was adjusted, based on ESRD facility audit data, and reduced to $127 for freestanding dialysis facilities and $131 for hospital-based dialysis facilities. Because the rate of growth in the ESRD population is decreasing, it is likely that the ESRD program costs will rise more slowly in the near future.

Distribution patterns of Medicare reimbursement

Although discussions of per capita reimbursements for the aged and disabled provide a broad overview of the average experience, they obscure the important fact that large variations exist in the use of services by beneficiaries. As shown in Table 27, the average Medicare reimbursement for an aged enrollee in 1983 was $1,724. Yet, as in all other years, a large proportion of aged enrollees in 1983 had small claims or none at all. As shown in Table 28, 37.4 percent of all aged enrollees had no reimbursements made on their behalf, and an additional 33 percent had reimbursements of less than $500. Thus, 70 percent had reimbursements less than $500 and 30 percent had reimbursements that were $500 or more.

About 24 percent of the aged were hospitalized in 1983, and the vast majority of these hospitalized enrollees (21 percent) fall within the 30 percent of enrollees with reimbursement of $500 or more (Helbing and Latta, 1985). The highest 9.6 percent of users had reimbursements of $5,000 or more, and reimbursements for those enrollees accounted for 72.2 percent of program payments.

The fact that a small proportion of enrollees uses a high proportion of program benefits raises questions as to whether or not benefits are being used appropriately. First, it should be observed that the underlying purpose of health insurance (and other types of insurance as well) is to provide protection against the risk of large, unexpected bills. From the National Medical Care Utilization and Expenditure Survey of the noninstitutionalized population (National Center for Health Statistics and Health Care Financing Administration, 1980), it was found that 63 percent of the aged considered their health to

Table 28

Percent distribution of Medicare enrollees 65 years of age or over and reimbursements, by reimbursement category: 1983

Reimbursement category	Enrollees	Reimbursements
	Percent distribution	
Total[1]	100.0	100.0
No reimbursement	37.4	0.0
$1-499	33.0	3.2
$500-1,999	11.4	7.5
$2,000-4,999	8.6	17.1
$5,000 or more	9.6	72.2

[1] In 1983, there were 28.6 million enrollees and $46.7 billion in reimbursements.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System.

be "excellent or good" and 60 percent had no functional limitations with regard to major or outside activities. The fact that 70 percent of the aged in 1983 had Medicare reimbursements of less than $500 seems to bear out the general relationship between health status and the use and costs of health care; namely, persons in good or excellent health tend to be low users of health care services.

These data cannot indicate the cost effectiveness of health care benefits used by the 30 percent of the aged who had reimbursements of $500 or more made on their behalf. Yet, the data can provide some insight as to: the characteristics of beneficiaries who are likely to have high reimbursements; the proportion of very high users; whether or not the concentration of Medicare benefits on a small number of users is increasing over time; and whether or not the Medicare experience in use of resources is different from that of the nonaged population.

One group of high users is aged enrollees with both Medicare and Medicaid entitlement. Far more of the dual enrollees use Part A and Part B services (even correcting for their older age) than Medicare enrollees without Medicaid entitlement. In 1978, Medicare reimbursements per enrollee for those without Medicaid averaged $799; for those with both Medicare and Medicaid, Medicare outlays were $1,283 (61 percent higher). In addition, Medicaid program outlays for the dual enrollees were estimated to be about $1,900. Thus, Medicare and Medicaid combined outlays for the dual enrollees were about $3,200 (McMillan et al., 1983).

In a study of another group of high users, Lubitz and Prihoda (1984) traced back the experience of aged Medicare beneficiaries, who died in 1978, for a full 12 months and found that reimbursements for these decedents averaged $4,527; reimbursements averaged $729 for a comparison group who survived during those 12 months under study. All decedents combined made up 6 percent of Medicare enrollees and 28 percent of program reimbursements. Thus, persons in their last years of life are likely to use Medicare benefits at a much greater rate than other enrollees. Although decedents are relatively high users, 88 percent of all decedents had Medicare reimbursements of less than $10,000 in the last 12 months of their life; only 6 percent of them in 1978 had reimbursements of $15,000 or more. A finer breakdown of these 6 percent showed that 3 percent had reimbursements between $15,000 and $19,999, 2 percent had reimbursements between $20,000 and $29,999, and 1 percent had reimbursements of $30,000 or more.

For more recent data, a special tabulation was made to examine the distribution of Medicare reimbursements for aged enrollees who died in 1983 (Helbing and Latta, 1985). For 52 percent of the decedents, Medicare reimbursements in the calendar year in which they died (that is, an average of 6 months' costs) were less than $5,000. For 38 percent of the decedents, reimbursements were between $5,000 and $19,999. For the remaining 10 percent, reimbursements were $20,000 or more. Thus, for 9 out of 10 persons who died in 1983, Medicare benefits that year were less than $20,000.

Not all of the high users of benefits are about to die; of all beneficiaries with $20,000 or more in Medicare reimbursements in 1983, 33 percent died and 67 percent survived. Thus, two out of three high users survive. The fate of the survivors in 1984 and beyond cannot be ascertained from these tabulations for 1983. In a recent study focusing on the costs of dying, Scitovsky (1984) observed: "It is easy enough, of course, to designate a patient as terminal or as dying retrospectively, but an entirely different matter to do so prospectively. Despite the enormous advances of modern medicine in the past 50 years, medical prognosis is still highly uncertain . . . . Today, predicting imminent death with any degree of certainty is difficult in the case of most patients and predicting death 12 or 6 or even 3 months in advance is well-nigh impossible. The main exceptions are cancer patients for whom a prognosis of death can be made with reasonable accuracy beyond a certain point in the course of the disease; and it is no accident that hospice programs serve primarily such patients."

Finally, Riley et al. (1985) looked at the distribution of Medicare expenditures among the aged to see if expenditures over time were being concentrated more on those with catastrophic illnesses. The study showed that the distribution had remained stable over time, with the top 2 percent of enrollees responsible for a similar proportion of reimbursements in 1969, 1975, and 1982. Other studies also have found remarkable consistency over time in the use of health care dollars by the highest users—and levels not dissimilar to the Medicare experience. For example, the Congressional Budget Office (1982) found that, for 1978, the top 1 percent of families consisting of Federal employees insured by the Blue Cross/Blue Shield Federal Employees Health Benefit Plan accounted for 22 percent of expenditures. Riley et al. (1985) found that the top 1 percent of aged Medicare beneficiaries accounted for 21 percent of Medicare expenditures in 1975 and 20 percent in 1982.

Thus, in summary, only 30 percent of Medicare enrollees in 1983 used $500 or more in benefits. Persons who are mortally ill are likely to be high users although among the high users, there are more survivors than decedents; the vast majority of enrollees are nonusers or small users of benefits in any 1 year. Moreover, it appears that the continuing rise in Medicare payments for those who are users has not been primarily the result of unbounded catastrophic outlays for persons who are very ill, but rather because of steady cost increases across all user levels.

Trends in Medicaid payments

Medicaid payments for 1975 and 1984 by type of service are summarized in Table 29. Total Medicaid benefit payments have grown far less rapidly than Medicare payments. From 1975 to 1984, Medicaid expenditures increased from $12.2 billion to $34.3

Table 29

Medicaid total payments, by type of service: Fiscal years 1975 and 1984

Type of service	1975 Amount in millions	1975 Percent distribution	1984 Amount in millions	1984 Percent distribution	Percent change 1975-84
Total	$12,242	100	$34,262	100	180
Inpatient hospital	3,374	28	9,066	26	169
Nursing home					
Skilled nursing facility	2,434	20	4,856	14	99
Intermediate care facility	1,885	15	5,899	17	213
Intermediate care facility for the mentally retarded	380	3	4,179	12	998
Physician	1,225	10	2,224	6	82
Outpatient	373	3	1,705	5	357
Drugs	815	7	1,979	6	143
Other	1,756	14	4,354	13	148

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Medicaid Statistics Branch.

billion (180 percent). During the same period, Medicare payments rose from $15.6 billion to $62.9 billion (303 percent).

Inpatient hospital care accounts for a much smaller proportion of Medicaid program dollars (26 percent in 1984) compared with Medicare program dollars (64 percent in 1983). This reflects, in part, the fact that for the dual eligibles, Medicare is the first payer for hospital care, with Medicaid covering the deductibles and coinsurance.

Nursing home care (SNF, ICF, and ICF/MR) is the largest component of the Medicaid budget, accounting for 43 percent of all Medicaid outlays in 1984. SNF and ICF payments, not including ICF/MR, are primarily for the aged, and accounted for 31 percent of Medicaid outlays in 1984.

Growth in spending for nursing home care other than ICF/MR has slowed considerably in recent years. Moreover, the share of nursing home care financed by public programs has also declined since 1979, from 56 percent in 1979 to 48 percent in 1983 (Gibson et al., 1984). Rymer, Burwell, and Madigan (1984) showed that, between 1973 and 1982, Medicaid spending on SNF and ICF (excluding ICF/MR) services remained at a constant level of about 34 percent of total Medicaid expenditures; in 1984, the proportion had fallen to 31 percent.

The overall growth in the proportion of total Medicaid spending for nursing home care is the result of rapid expansion in intermediate care facilities for the mentally retarded, a Medicaid benefit first offered in 1972. Since then, payments for ICF/MR were the most rapidly growing benefit financed by Medicaid. In 1975, only $0.38 billion (3 percent) of Medicaid payments were for ICF/MR services; by 1984, $4.2 billion was paid for ICF/MR services (12 percent of total Medicaid outlays). The rapid growth in ICF/MR payments is primarily attributable to the certification of State institutions for the mentally retarded as ICF/MR facilities.

During the period 1977-82, the number of ICF/MR Medicaid certified beds increased 40 percent; analysis of current trends indicates that the rapid growth of ICF/MR will slow over the next few years as the pool of beds eligible for Medicaid certification dwindles (Gibson et al., 1984). In 1984, payments for ICF/MR rose by only 2.5 percent over the previous year, below the overall increase of 5.8 percent in Medicaid expenditures.

The average Medicaid payment per recipient in 1975 and 1984 by type of service is shown in Table 30. These figures indicate clearly that payments for long-term care services in nursing homes are the most costly per user of service. In 1984, for recipients of SNF and ICF services, the average Medicaid payment was $8,594 and $7,377, respectively; for recipients of ICF/MR services, the average Medicaid payment was $29,995.

Table 30

Medicaid payments per recipient, by type of service: Fiscal years 1975 and 1984

Type of service	1975	1984	Percent change 1975-84
Total	$556	$1,604	188
Inpatient hospital	983	2,510	155
Nursing home			
Skilled nursing facility	3,864	8,594	122
Intermediate care facility	2,764	7,377	167
Intermediate care facility for the mentally retarded	5,507	29,995	445
Physician	81	157	94
Outpatient	50	175	250
Drugs	58	141	143
Other	(1)	(1)	(1)

[1] Miscellaneous category.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Medicaid Statistics Branch.

The substantial increase in payments for ICF/MR services under Medicaid had a profound effect on the distribution of Medicaid benefits by eligibility category. Changes in Medicaid payments from 1975 to 1984, by eligibility category, are shown in Table 31. In 1975, AFDC families accounted for 14.1 million persons (64.2 percent of the Medicaid recipient population), but they accounted for only 34.7 percent of total Medicaid payments. In 1984, although the number of AFDC recipients (15.3 million) and proportion (67.8 percent) of the total population had risen slightly, their share of Medicaid outlays fell to only 25.2 percent. As shown in Figure 2, AFDC children were the largest group of recipients in 1984 and accounted for a relatively small part of the Medicaid budget. Per capita outlays per AFDC child recipient was $418, a figure far below the average outlay for other Medicaid groups. These findings confirm the results of the 1980 National Medical Care Utilization and Expenditure Survey that showed most Medicaid children to be in good health, although 7 percent of Medicaid children compared with only 3 percent of non-Medicaid children were perceived to be in fair or poor health (Kasper and Howell, 1985).

The number of aged SSI recipients fell from 3.6 million recipients to 3.2 million, but their share of Medicaid outlays rose slightly from 35.6 percent to 37.3 percent, probably reflecting the small increase in nursing home users (excluding ICF/MR) between 1975 and 1984.

Rymer, Burwell, and Madigan (1984) observed that the growth in the aged Medicaid nursing home population has lagged behind overall demographic trends. From 1975 to 1982, the number of aged nursing home patients receiving Medicaid increased by about 11 percent. During the same period, the total elderly population increased by almost 20 percent.

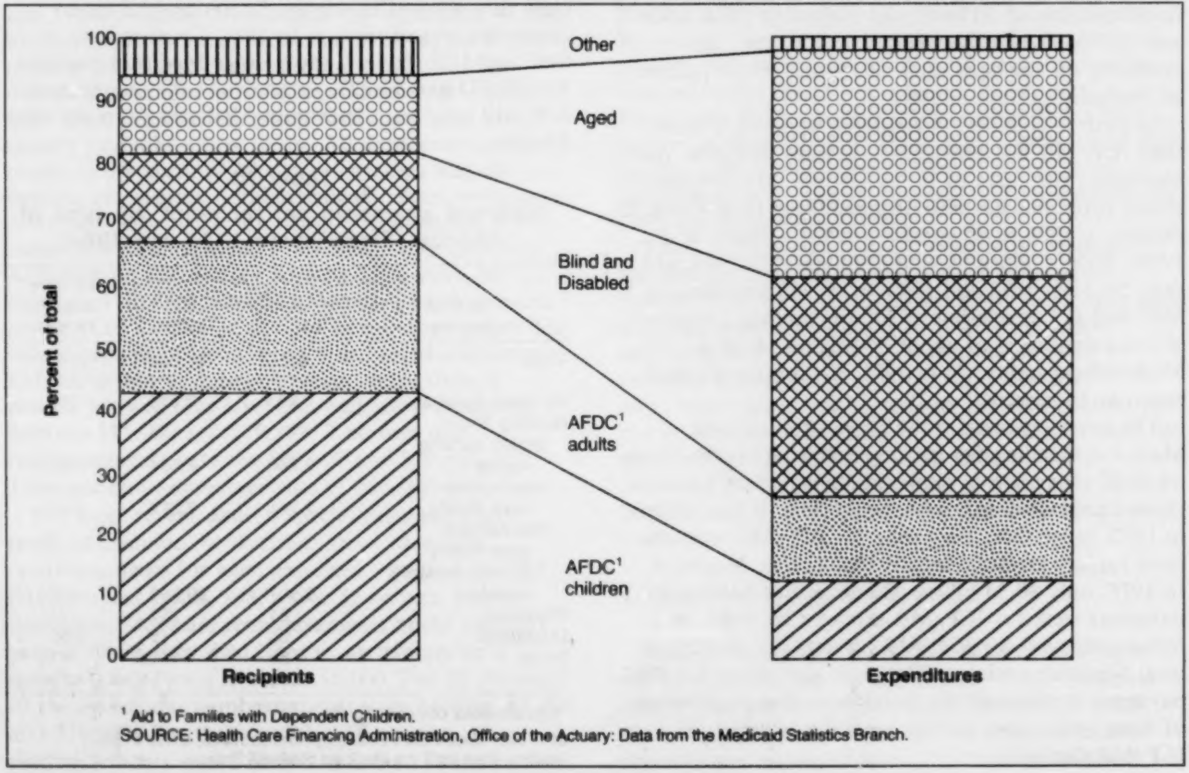
The most dramatic change occurred with the disabled population. Although there was only a small growth in recipients from 2.4 million in 1975 to 2.9 million in 1984, Medicaid outlays for the disabled increased from $3.0 billion (24.9 percent) to $11.7 billion (34.3 percent) of the total. The high rate of increase reflected, in part, the $4.2 billion expenditures for the 139,000 disabled persons in ICF/MR facilities.

State expenditures for Medicaid

Medicaid is the fastest growing component of aggregate State spending and it is growing faster than State revenues. Between 1965 and 1981, State Medicaid expenditures have gone from 2 percent of total State spending to 7.7 percent of State spending,

Figure 2

Distribution of Medicaid recipients and expenditures, by eligibility category: United States, 1984



[1] Aid to Families with Dependent Children.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Medicaid Statistics Branch.

Table 31

Number of Medicaid recipients, total payments, and average payment per recipient, by basis of eligibility: Fiscal years 1975 and 1984

	Recipients				Total Medicaid payments				Average payment per recipient		
	1975		1984		1975		1984				
Basis of eligibility	Number in thousands	Percent	Number in thousands	Percent	Amount in millions	Percent	Amount in millions	Percent	1975	1984	Percent change 1975-84
Total	22,007	100.0	21,365	100.0	$12,242	100.0	$34,262	100.0	$556	$1,604	188
Aid to Families with Dependent Children:											
Children	9,598	43.6	9,771	43.1	2,186	17.9	4,083	11.9	228	418	83
Adults	4,529	20.6	5,598	24.7	2,062	16.8	4,548	13.3	455	812	78
Supplemental Security Income:											
Aged	3,615	16.4	3,166	14.0	4,359	35.6	12,775	37.3	1,205	4,035	235
Blind	109	0.5	80	0.3	93	0.8	220	0.6	850	2,753	224
Disabled	2,355	10.7	2,870	12.7	3,052	24.9	11,748	34.3	1,296	4,094	216
Other Title XIX recipients	1,800	8.2	1,184	5.2	492	4.0	889	2.5	273	751	175

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Medicaid Statistics Branch.

Table 32

Expenditures for selected public activities as a percentage of total States' expenditures: Selected years 1959-81

Public service	1959	1961	1963	1965	1967	1969	1971	1973	1975	1977	1979	1981	Percent change 1959-81
Education	35.4	36.6	37.3	38.3	40.8	40.4	39.2	38.4	38.3	37.7	36.6	35.9	1.4
Highways	19.6	17.5	16.8	16.4	14.9	13.2	12.0	10.3	9.8	8.5	8.7	8.5	-56.6
Welfare	8.2	8.4	8.5	6.4	5.8	6.6	8.1	7.9	6.2	6.3	5.7	5.1	[1]-20.3
Medicaid				2.0	3.0	3.7	3.9	5.1	5.6	6.3	6.7	7.7	[1]285.0
Health and hospitals	7.9	7.1	6.6	7.2	7.1	7.3	7.4	7.7	8.2	8.3	8.7	8.9	23.6
Police and fire	5.4	5.5	5.3	5.2	4.8	4.9	5.0	5.4	5.2	5.4	5.3	5.2	-3.7
All other services	23.6	24.9	25.4	24.5	23.7	23.8	24.3	25.3	26.7	27.6	28.3	28.6	21.2
Medical vendor payments as a percentage of total welfare expenditures	—	—	—	23.8	34.0	35.9	32.5	39.2	47.5	50.0	54.0	60.2	[1]152.9

[1] Percent change was calculated from 1965-81.

SOURCE: (Cromwell et al., 1984).

a relative increase of 285 percent (Table 32). During that same period of time, Medicaid payments have gone from 23.8 percent of total State welfare expenditures to 60.2 percent of welfare expenditures, reflecting, in large part, the fact that cash assistance payments have risen very slowly compared with the rise in the cost of health care services.

Another measure of the increasing burden of the Medicaid program on States is the growth in Medicaid spending relative to the growth in State revenues. According to Rymer, Burwell, and Madigan (1984), Medicaid expenditures increased at an annual compound rate of 16.9 percent for the years 1972-82. This compares with only an 11.4 percent annual compound growth rate in State revenues. Some of the growth rate of Medicaid expenditures, however, reflects shifts (such as for ICF/MR services) from other parts of State budgets to Medicaid.

Discussion of national Medicaid expenditure levels obscures the fact that there are considerable variations by State. A recent study by Cromwell et al. (1984) illustrates the fact that Medicaid expenditures vary greatly across States. Although it is difficult to find a single best measure to index this variation, the use of expenditures per capita (i.e., per resident) and expenditures per person in poverty (with poverty levels adjusted for differences in cost-of-living across States) seem to be reasonable first approximations. Both of these indices show great variation in expenditures. For example, in 1984, four States had per capita Medicaid expenditures of less than $70, and four States had per capita expenditures of more than $190. Similarly, seven States had Medicaid expenditures per person in poverty of less than $500, and eight States had per person in poverty expenditures of $1,500 or more.

Trends in health care outlays

Trends since 1940 in health care spending for the Nation as a whole and for the Medicare and Medicaid programs are shown in Table 33. Spending for health care has steadily increased both in terms of dollars and in terms of the general economy. In 1984, national health expenditures constituted 10.6 percent of the gross national product (GNP), compared with 5.3 percent in 1960. A variety of factors is generally believed to have contributed to the disproportionate growth in health care spending relative to the GNP, including rising expectations in the Nation about the value of health care services, rapid development and dissemination of medical technology which expanded the treatment of disease, government financing of health care services, the nature of third-party reimbursement; and the lack of competitive forces in the health care system to increase efficiency and productivity in the delivery of health care services.

Spending for Medicare and Medicaid has been increasing even faster than total health care spending (Table 33). In 1984, Medicare and Medicaid spending together reached $103.3 billion (26.7 percent of the $387.4 billion total health care bill); in 1967, Medicare and Medicaid spending together represented only 15 percent of the total health care bill. However, the increase in national health expenditures from 1983 to 1984 was 9.1 percent, the lowest annual increase in 20 years; only a few years ago, the annual rise was much greater (15.3 percent in 1980 and 15.2 percent in 1981).

Expenditures in 1984 for personal health care services (which exclude national spending on research and medical facilities) and the share Medicare and Medicaid contributed, as well as other sources of funding, are shown in Figure 3. For all services

Table 33

Medicare and Medicaid expenditures as a percent of total national health expenditures: Selected calendar years, 1940-84

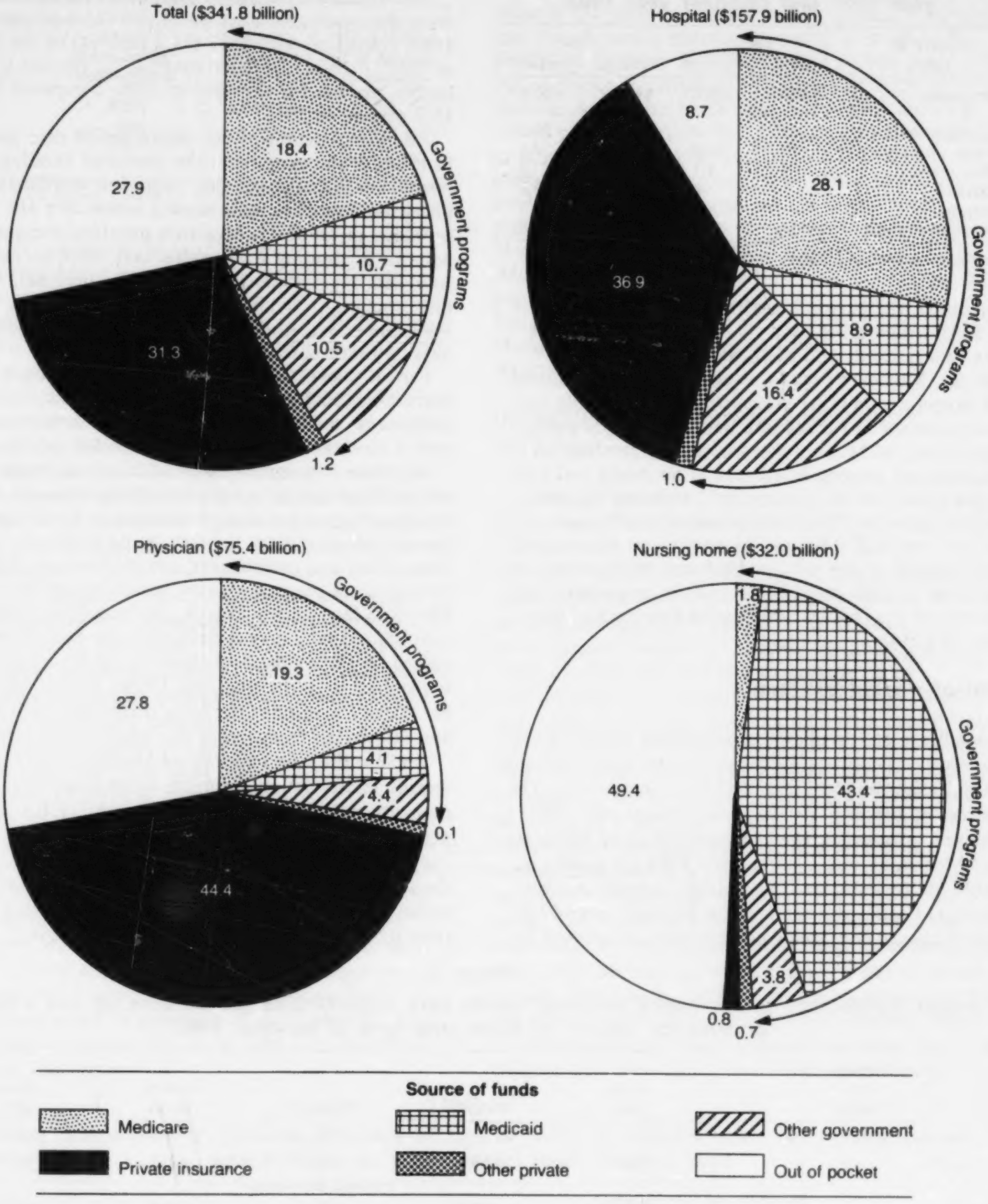
			Medicare and Medicaid			
Year	National health expenditures in billions	Percent of gross national product	Total in billions	Medicare in billions	Medicaid in billions	Percent of national health expenditures
1940	$4.0	4.0	—	—	—	—
1950	12.7	4.4	—	—	—	—
1960	26.9	5.3	—	—	—	—
1965	41.7	6.0	—	—	—	—
1967	51.1	6.4	$7.7	$4.7	$3.0	15.0
1970	74.7	7.5	13.0	7.5	5.5	17.4
1975	132.7	8.6	30.4	16.3	14.1	22.9
1980	249.0	9.5	63.6	36.8	26.8	25.5
1981	286.6	9.8	75.4	44.8	30.6	26.3
1982	322.4	10.5	86.2	52.2	34.0	26.8
1983	355.1	10.8	94.6	59.0	35.6	26.6
1984	387.4	10.6	103.3	64.6	38.7	26.7
ACRG[1]	12.6	—	16.5	16.7	16.2	—

[1] Annual compound rate of growth 1967-84.

NOTE: Medicare and Medicaid expenditures include administrative expenses.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of National Cost Estimates.

Figure 3
Personal health care expenditures for total population, by type of service[1] and source of funds: United States, 1984



[1] All other services combined (including drugs, dental, eyeglasses, etc.) accounted for $76.5 billion of the total and is not shown as a separate pie chart.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of National Cost Estimates.

Table 34

Percent distribution of per capita personal health care expenditures for persons 65 years of age or over, by source of funds: Fiscal year 1966 and calendar year 1984

Source of funds	1966 Amount	1966 Percent	1984 Amount	1984 Percent
Per capita	$445	100.0	$4,202	100.0
Out-of-pocket	237	53.2	1,059	25.2
Private insurance	71	15.9	304	7.2
Other private	5	1.1	16	.4
Medicare	—	—	2,051	48.8
Medicaid	—	—	536	12.8
Other government	133	29.8	236	5.6

SOURCES: (Mueller and Gibson, 1976; Waldo and Lazenby, 1984).

combined, the personal health care bill in 1984 came to $341.8 billion. Medicare's share of the total bill was 18.4 percent, and Medicaid's share was 10.7 percent. Medicare's role was clearly most substantial for hospital care (28.1 percent); Medicaid's role was most substantial for nursing home care (43.4 percent). The impact of Medicare and Medicaid funding for hospital and nursing home care is no doubt reflected in the growth of these two services during the past two decades. In 1965, total personal health care outlays were $35.9 billion. Hospital care represented 39.0 percent of the total in 1965 and 46.2 percent of the total in 1984; nursing home care represented 5.8 percent of the total in 1965 and 9.4 percent of the total in 1984.

Out-of-pocket payments

Medicare and Medicaid expenditures represent the majority of health care outlays for the aged, although a significant amount is funded by other sources. The sources of funding for the aged in fiscal year 1966 (the year proceeding the implementation of Medicare and Medicaid) and calendar year 1984 are shown in Table 34. In 1984, total per capita expenditures for personal health care services for the aged were $4,202, and Medicare and Medicaid combined accounted for 61.6 percent of the total. Other government sources funded 5.6 percent. Thus, total government outlays for the aged in 1984 were 67.2 percent, compared with 29.8 percent in fiscal year 1966.

Out-of-pocket payments (that is, direct payments from the aged) amounted to $1,059 (25.2 percent) in 1984, compared with $237 (53.2 percent) of the total in 1966. Private insurance covered 7.2 percent of the health care bill for the aged in 1984, compared with 15.9 percent in 1966.

Additional details of per capita health care spending in 1984 for the aged, with the source of funding for hospital care (inpatient and outpatient combined), physicians' services, and nursing home care are provided in Table 35. Medicare provided the greatest amount of funding for hospital care (74.8 percent), followed by physicians' services (57.8 percent), with a tiny fraction of funding for nursing home care. Medicaid provided the greatest amount of funding for nursing home care (41.5 percent).

Out-of-pocket liability was greatest for nursing home care (50.1 percent), and substantial for physicians' services (26.1 percent). For hospital care, only 3.1 percent was from out-of-pocket payments.

The Part A program under Medicare accounts for about 70 percent of program outlays, although it is the Part B program that is responsible for about 70 percent of beneficiary liability in the form of deductibles and coinsurance under Medicare. This follows from the cost-sharing provisions of the Medicare law. Under Part A, the beneficiary who is hospitalized must pay a deductible for each benefit period, but after the deductible is met no coinsurance is required until the 61st day. Under Part B, the beneficiary is responsible for a deductible each year and 20-percent coinsurance for nearly all services.

Because the vast majority of Medicare enrollees require relatively low program reimbursements, the majority experience relatively low liability for the deductibles and coinsurance required by the program. For 1984, it was estimated that 92 percent had less than $1,000 in liability from the deductibles and coinsurance under Medicare, and 8 percent had more than that (Gornick, Beebe, and Prihoda, 1983).

Table 35

Percent distribution of per capita personal health care expenditures for persons 65 years of age or over, by source of funds and type of service: 1984

Source of funds	Total care	Hospital	Physician	Nursing home	Other care
			Amount		
Per capita	$4,202	$1,900	$868	$880	$554
			Percent distribution		
Total	100.0	100.0	100.0	100.0	100.0
Out-of-pocket	25.2	3.1	26.1	50.1	59.9
Private insurance	7.2	7.9	13.5	1.1	4.9
Other private	.4	.4	.0	.7	.5
Medicare	48.8	74.8	57.8	2.1	19.9
Medicaid	12.8	4.8	1.9	41.5	11.4
Other government	5.6	9.1	.7	4.4	3.4

SOURCE: (Waldo, and Lazenby, 1984).

Table 36

Mean out-of-pocket health costs as a percent of income for persons 65 years of age or over: Selected years 1966-84

Year	Mean out-of-pocket expenditures	Mean personal income	Out-of-pocket as a percent of income
1966	$300	$2,000	15
1977	690	5,592	12
1981	1,187	8,639	14
1984	1,575	10,615	15

SOURCE: (U.S. Senate, Special Committee on Aging, 1984).

Nearly 70 percent of the aged purchase "Medigap" policies that cover some or all of the cost-sharing requirements under Medicare. Yet, even with coverage of physicians' services by Medicare and Medigap (and Medicaid for the poor aged), the aged as a group still pay 26.1 percent in out-of-pocket payments for physicians' care; these payments are primarily for uncovered services, such as preventive care, and for charges above the Medicare allowed charge that neither Medicare nor Medigap policies will cover. In contrast, beneficiary liability for inpatient hospital care under Part A came to 7 percent of total hospital charges in 1983, and Medigap policies generally cover that liability.

The U.S. Senate's Special Committee on Aging (1984) estimated out-of-pocket expenditures as a percent of mean income for 1966, 1977, 1981, and 1984 (Table 36). As a percent of mean income, out-of-pocket expenditures (which included direct out-of-pocket payments plus insurance premiums) were estimated at 15 percent in 1966 and 12 percent in 1977. In 1981 and 1984, their estimates were 14 percent and 15 percent, respectively.

HCFA's Office of the Actuary also estimated out-of-pocket expenditures as a percent of mean income for 1965 and 1983. It was estimated that the elderly paid 10-12 percent in direct out-of-pocket payments, excluding insurance premiums, in 1983, and the percentage was in the same 10-12 percent range in 1965 (Lazenby and Waldo, 1985). Thus, from each of these sources, it appears that the out-of-pocket burden, measured as a percent of mean income, has been at approximately the same level since Medicare and Medicaid began.

A different look at the burden of out-of-pocket expenses is shown in Table 37, in which a distribution of aged persons according to the percent of income used for out-of-pocket expenses in 1980 is given. For those in the poor/near poor income group, 6 percent had out-of-pocket expenses amounting to 10-14.9 percent of income; an additional 12 percent had out-of-pocket expenses of 15 percent or more of income. As income levels rose, the proportion with out-of-pocket expenses that amounted to 10 percent or more of income fell sharply. The burden of medical care services is inversely related to income levels and is still quite high for the lowest income group. In that lowest income group, the aged with Medicaid have a relatively low out-of-pocket burden (McMillan and Gornick, 1984). Thus, if the poor/near poor group were separated into two groups, the figures for the poor/near poor income group without Medicaid would show an even greater burden than depicted in Table 37.

International health care expenditures increases

Although there has been a rapid rise in public and private spending for health care in this country, this increase is not unique to the United States or associated with a particular type of financing system. Data on health care expenditures as a percent of gross national product (GNP) for nine advanced industrialized nations for 1960-80 are presented in Table 38. Although the rate of growth varies considerably across countries, none of these countries had increases in GNP spending on health care of less than 32 percent, and two-thirds had increases of more than 75 percent. The rates of growth do not seem to be related to either the initial percent of GNP spent on health or a particular financing mechanism. In 1980, five of the nine countries had health care expenditures that represented 9 percent or more of their GNP. France at 8.9 percent was close to the mark. The United Kingdom and Canada were the only countries with considerably lower percentages of their GNP devoted to health care. The size of social insurance and social welfare programs, as well as the size of health care expenditures, is a growing concern in many countries. Reports from these other countries indicate that they share, to a remarkable degree,

Table 37

Percent distribution of persons 65 years of age or over, by income group and out-of-pocket expenditures as a percent of total income: 1980

Income group	Total	Out-of-pocket expenditures: Less than 5 percent of income	5-9.9 percent of income	10-14.9 percent of income	15 percent or more of income
Poor/near poor	100.0	67	15	6	12
Low income	100.0	73	17	3	7
Middle income	100.0	88	9	2	1
High income	100.0	96	3	1	0

SOURCE: (National Center for Health Statistics and Health Care Financing Administration, 1980).

Table 38

Health care expenditures as a percent of gross national product for selected countries: 1960-80

Country	1960	1965	1970	1975	1980	Percent increase 1960-80
United States	5.3	6.0	7.5	8.6	9.5	79
Australia	5.0	5.2	5.6	7.0	9.8	96
Canada	5.6	6.1	7.1	7.1	7.4	32
Finland	4.2	5.2	5.9	6.8	—	[1]62
France	5.0	5.9	6.6	8.1	8.9	78
Federal Republic of Germany	4.4	5.2	6.1	9.7	9.6	118
Netherlands	—	5.0	6.3	8.6	9.1	[2]82
Sweden	3.5	5.8	7.5	8.7	9.4	169
United Kingdom	3.8	3.9	4.9	5.6	5.8	53

[1] Percent increase calculated for 1960-75.

[2] Percent increase calculated for 1965-80.

SOURCES: Health Care Financing Administration, Office of the Actuary: Data from the Division of National Cost Estimates; (Simanis and Coleman, 1980; Simanis, 1985).

many of the same issues, policy debates, and dilemmas that confront the United States.

Summary and conclusions

This compilation of data suggests that there is a broad basis of information to draw on in gaining an understanding of the 20-year experience of Medicare and Medicaid program beneficiaries. The following is a summary of the most relevant facts to consider as decisions are made in the future about the beneficiary populations and the structure of the programs.

Medicare was designed so that nearly the entire aged population became eligible for hospital care on the day the program was implemented. On June 30, 1966, there were more than 8 million people or 44 percent of the population 65 years of age or over without hospital insurance. On July 1, 1966, 19.1 million aged persons, virtually the entire population 65 years or over, were enrolled in Medicare. This striking alteration in the level of health insurance coverage among the aged was a major factor in the rapid and far-reaching impact that Medicare had on the aged population, in particular, and on the health care system, in general. In contrast, it took several decades after the enactment of the social security program in 1935 before most of the aged were eligible for social security benefits.

During the past 20 years, the number of aged persons enrolled in the Medicare program has grown to more than 28 million, with the program covering 75 percent of hospital and 58 percent of physicians' expenditures for the aged in 1984. During this time, mortality rates in the aged population declined more sharply than before, and many believe these reductions reflect improved access to health care services, improved treatment, and the general improvement in the economic circumstances of the aged. The aged increased in both absolute numbers and in relative terms during the past 20 years, and projections for the next several decades indicate that the percentage of the population over age 65 will continue to grow. Another finding is that differences by race in the use of health care services diminished significantly, reflecting both the fact that participation in Medicare required that hospitals be desegregated and that reimbursement by Medicare enabled minority and low-income elderly access to care.

A review of the characteristics of the aged and their use and cost of services suggests that there are subsets of the aged who may be most vulnerable to future changes in the Medicare program or to changes in the health care sector. Although, as a group, the aged are much better off today than they were when Medicare began, a wide range in income still exists, with 12 percent (3.3 million) of the aged living at or below the poverty level in 1984. Those most at-risk to being poor are minorities, women, persons living alone, and the older elderly. Future program changes should be assessed in terms of continued access to care for these highly vulnerable populations.

Unless catastrophic protection is provided, the elderly who are in ill health may also be at-risk to financial insecurity as a result of future changes in Medicare cost sharing. The need for services is not uniform across the aged population. Rather, the distribution of services on an annual basis is similar to that of other insured groups, with most persons using only a small amount of services, and a small percentage using relatively large amounts of services. The life cycle is such that the final years are often preceded by illness and the need for hospital and medical services. Some of the aged, however, experience costly illnesses, and live for several years. Because existing cost-sharing provisions are tied into the use of services, the elderly who are in poor health currently experience the highest beneficiary liability. To prevent undue financial burden, the liability of beneficiaries in the event of catastrophic illness should be considered in future cost-sharing reform.

The elderly who are in poorer than average health are also vulnerable to changes in the health care system. As health care becomes oriented to a more competitive market system, insurers and providers of prepaid capitated systems may seek to enroll the healthiest and, hence, lowest users of health care resources. Unless incentives are there to provide services for the elderly with chronic illnesses and functional limitations, access to care for this group could be diminished. This suggests that Medicare payment for future health care delivery systems must be fair from both the beneficiary and provider perspective.

The Medicaid program has had a major role in filling the gaps in the needs of low-income elderly and the long-term care needs of the aged in general. In 1984, Medicaid covered 13 percent of the total health care expenditures of the aged. For many of the poor and near-poor elderly living in the community, Medicaid provides needed services that Medicare does not cover, such as drugs, eyeglasses, hearing aids, and the premiums, deductibles, and coinsurance that Medicare-covered services require. The noninstitutionalized low-income elderly with dual coverage in Medicare and Medicaid are a high-risk group, with substantially higher health care use and higher mortality rates than the aged who are in better economic circumstances.

Because Medicare is the first payer for hospital and medical bills, Medicaid expenditures for the noninstitutionalized aged are relatively low. Most of Medicaid outlays for the aged are for nursing home care, and these payments account for a substantial portion of the Medicaid budget. In 1984, Medicaid expenditures for SNF and ICF services (excluding services for the mentally-retarded) amounted to 31 percent of total Medicaid spending. Medicaid has become the principal third-party payer for long-term care; few of the aged have insurance for nursing home care, and many who enter a nursing home as private pay patients exhaust their assets and become dependent on Medicaid. In 1984, 50 percent of all nursing home expenditures for the aged were paid for out of pocket, and 42 percent were funded by Medicaid. Medicare covered only 2 percent of total nursing home costs for the aged, and only for services that qualified as post-hospital skilled nursing facility care.

Both Medicare and Medicaid play a significant role in providing access to care for severely disabled persons under age 65 who are unable to engage in any substantial gainful activity and whose impairment is expected to result in death or to continue for not less than 12 months. In 1984, Medicare and Medicaid each had about 3 million persons enrolled because of disability, with about a 20 percent overlap in enrollees.

The disabled under Medicare are primarily disabled workers and disabled widows, although 16 percent are adults disabled in childhood, half of whom are mentally retarded. Black people make up a higher proportion of the disabled population than the proportion they represent of the general population. The disabled workers and widows have proved to be a high-risk group, experiencing mortality rates that are 6.6 times the mortality rates of the general population in the same age range. In 1983, Medicare per capita expenditures for the disabled ($1,900) were a little higher than for the aged ($1,724); the group disabled in childhood, however, have relatively low per capita expenditures under Medicare, averaging one-half to one-third of the costs of other Medicare enrollees. Under Medicare, the disabled as a group (including people with ESRD) account for about 10 percent of all enrollees and about 13 percent of total outlays.

The disabled under Medicaid have a much greater impact on the Medicaid budget. In 1984, they accounted for about 13 percent of the recipient population and 34 percent of Medicaid spending, with ICF services for the mentally retarded accounting for 12 percent of all Medicaid outlays. In 1984, ICF services for the mentally retarded averaged nearly $30,000 per capita for the 139,000 Medicaid recipients of these services.

The entitlement of ESRD patients to Medicare had a striking impact on access to care for persons with kidney failure. With the implementation of the program, the number of enrollees being treated for ESRD rose rapidly, increasing from 16,000 persons in 1974 to 82,000 persons in 1983. The rate of growth has slowed, with the ESRD population increasing 9 percent in 1983 over the previous year. The presence of ESRD is notably high in minority people; people of all races other than white account for 32 percent of the ESRD population, whereas white people account for 68 percent.

Medicare per capita payments in 1983 were $23,000 for ESRD enrollees. Despite the high per capita costs for ESRD enrollees, costs per enrollee have been growing at a much lower rate than that for the aged and the disabled, reflecting the fact that dialysis charges were set at a maximum rate in 1973 and remained unchanged until August 1983.

A salient feature of the ESRD program is the impact of different treatments. Persons undergoing transplantation have better survival rates and continue to work or attend school at a much higher rate than ESRD patients on dialysis. The recent use of the immunosuppressant drug, cyclosporine, has been shown to significantly improve the survival of kidney grafts.

The AFDC population is the largest category under Medicaid, consisting of families of children and mothers, eligible primarily because they are poor. These children and adults constituted nearly 68 percent of all Medicaid recipients in 1984, but accounted for only 25 percent of outlays. Prior to the implementation of Medicaid, the percentage of persons from families below the poverty level who saw a physician during the year was considerably below the level for persons from high-income families. In the past 20 years, disparities by income have essentially disappeared. In addition to the increase in the proportion of poor persons who saw a physician, the number of visits per person rose and, in 1980, the visit rate for the poor exceeded that for high-income families, reflecting the greater health care needs among the poor, especially in adult and older age groups.

Expenditures for the AFDC child who received services averaged $418 in 1984. These relatively low Medicaid outlays reflect the fact that AFDC children are primarily healthy and expenditures for them are for relatively inexpensive ambulatory care services. In striking comparison, Medicaid outlays in 1984 for mentally retarded recipients in ICF facilities averaged $30,000. Consequently, the total Medicaid outlay for the 10 million child recipients in the AFDC category ($4.1 billion) was nearly equal to the expenditure for the 139,000 recipients of ICF/MR care ($4.2 billion). Medicaid also served an additional 1.2 million children in 1984, categorized as "other Title XIX recipients" who are eligible as foster care, "Ribicoff kids," and other low-income medically needy children. Compared with AFDC children, per capita expenditures for these children averaged $751 or nearly 80 percent more, reflecting the fact that the Medicaid program has the option of targeting to certain high-risk, noncategorical groups.

Because States exercise different options in their cash assistance programs and in their Medicaid programs, eligibility of the poor for Medicaid varies by State. In 1980, nationally, 58 percent of poor children under 19 years of age were covered part or all of the time by Medicaid. Although similar statistics for children are not available for the individual States, the ratio of the number of Medicaid recipients to the number of poor persons varies widely across States.

In the first two decades of Medicare and Medicaid, the overriding concern has been the escalation in health care expenditures. Between 1967 and 1984, national health expenditures increased from 6.4 percent to 10.6 percent of the GNP, and Medicare and Medicaid's share of the health care outlays rose from 15.0 percent to 26.7 percent of the total. From the perspective of the elderly, the implementation of the Medicare and Medicaid programs reduced their out-of-pocket expenditures as a percent of total per capita health care expenditures. However, as a result of the escalation in health care costs, the percent of income the aged spend out-of-pocket for health care now is essentially the same as before the programs were enacted.

In 1984, there were indications that the spiral in health care outlays was beginning to end. The Medicare hospital prospective payment system is generally believed to have contributed to this event, reflecting the fact that hospital days of care for Medicare patients represent 41 percent of the total. The development of future program policies is made more complicated by the rapidly changing health care sector. It is hoped that the downward trend in health care outlays will continue. The challenge in the new environment is to assure access and quality of care for the Nation as the rate of increase of health care expenditures is abated.

References

Aday, L., Andersen, R., and Fleming, G.: *Health Care in the United States: Equitable for Whom?* Beverly Hills. Sage Publications, 1980.

Advisory Council on Social Security: *The Status of the Social Security Program and Recommendations for its Improvement*. Washington. U.S. Government Printing Office, 1965.

Andersen, R., Lion, J., and Anderson, O.: *Two Decades of Health Services: Social Survey Trends in Use and Expenditures*. Cambridge, Mass. Ballinger Publishing Co., 1976.

Arnett, R. H., Cowell, C. S., Davidoff, L. M., and Freeland, M. S.: Health spending trends in the 1980's: Adjusting to financial incentives. *Health Care Financing Review*. Vol. 6, No. 3. HCFA Pub. No. 03198. Office of Research and Demonstrations, Health Care Financing Administration. Washington. U.S. Government Printing Office, Spring 1985.

Baugh, D.: Office of Research and Demonstrations, Health Care Financing Administration. Personal communication, 1985.

Binstock, R.: The oldest-old: A fresh perspective or compassionate ageism revisited? *Milbank Memorial Fund Quarterly* 63(2):420-451, Spring 1985.

Brehm, H. P., and Cormier, R. H.: Medical care costs for the disabled. *Social Security Survey of the Disabled: 1966*. Report No. 8. DHEW Pub. No. (SSA)73-11713. Office of Research and Statistics, Social Security Administration. Washington. U.S. Government Printing Office, Jan. 1970.

Clinkscale, R., McCue, S., Fisher, M., et al.: *Analysis of State Medicaid Program Characteristics, 1983*. HCFA Contract No. 500-81-0040. Prepared for Health Care Financing Administration, Department of Health and Human Services. Rockville, Md. LaJolla Management Corporation, Dec. 1983.

Congressional Budget Office: *Catastrophic Medical Expenses: Patterns in the Non-Elderly, Non-Poor Population*. Washington. Congress of the United States, Dec. 1982.

Congressional Budget Office: *Reducing Poverty Among Children*. Washington. Congress of the United States, May 1985.

Cormier, R.: Social Security Administration, Office of Disability. Personal communication, 1985.

Cromwell, J., Davidson, S., Schurman, R., et al.: *The Evolution of State Medicaid Program Changes*. Grant No. 066A-83. Final report prepared for the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services. Chestnut Hill, Mass. The Center for Health Economics Research and Northwestern University, 1984.

Davis, K.: Equal treatment and unequal benefits: The Medicare program. *Milbank Memorial Fund Quarterly* 53(4):449-488, Fall 1975.

Doty, P., and Liu, K.: An overview of long-term care. *Health Care Financing Review*. Vol. 6, No. 3. HCFA Pub. No. 03198. Office of Research and Demonstrations, Health Care Financing Administration. Washington. U.S. Government Printing Office, Spring 1985.

Duchnok, S.: Health insurance coverage and medical care utilization, 1972. *Disability Survey 72: Disabled and Nondisabled Adults, A Monograph*. Research Report No. 56. SSA Pub. No. 13-11812. Office of Research and Statistics, Social Security Administration. Washington. U.S. Government Printing Office, Apr. 1981.

Eggers, P.: Risk differential between Medicare beneficiaries enrolled and not enrolled in an HMO. *Health Care Financing Review*. Vol. 1, No. 3. HCFA Pub. No. 03027. Office of Research, Demonstrations, and Statistics, Health Care Financing Administration. Washington. U.S. Government Printing Office, Winter 1980.

Eggers, P.: Trends in Medicare reimbursement for end-stage renal disease, 1974-79. *Health Care Financing Review*. Vol. 6, No. 1. HCFA Pub. No. 03176. Office of Research and Demonstrations, Health Care Financing Administration. Washington. U.S. Government Printing Office, Sept. 1984.

Eggers, P., Connerton, R., and McMullan, M.: The Medicare experience with end-stage renal disease: Trends in incidence, prevalence, and survival. *Health Care Financing Review*. Vol. 5. No. 3. HCFA Pub. No. 03169. Office of Research and Demonstrations, Health Care Financing Administration. Washington. U.S. Government Printing Office, Spring 1984.

Eggers, P., and Priholda, R.: Pre-enrollment reimbursement patterns of Medicare beneficiaries enrolled in "at-risk" HMO's. *Health Care Financing Review*. Vol. 4, No. 1. HCFA Pub. No. 03146. Office of Research and Demonstrations, Health Care Financing Administration. Washington. U.S. Government Printing Office, Sept. 1982.

Ermann, D., and Gabel, J.: The changing face of American health care: Multihospital systems, emergency centers, and surgery centers. *Med Care* 23(5):401-420, May 1985.

Evans, R. W., Blagg, C. R., and Bryan, F. A.: A social and demographic profile of hemodialysis patients in the U.S. *JAMA* 245(5):487-491, Feb. 6, 1981.

Evans, R. W., Manninen, D. L., Garrison, L. P., et al.: The quality of life of patients with end-stage renal disease. *New England Journal of Medicine* 312(9):553-559, 1985.

Ferron, D. T.: Medical care charges for the disabled and nondisabled, 1972. *Disability Survey 72: Disabled and Nondisabled Adults, A Monograph*. Research Report No. 56. SSA Pub. No. 13-11812. Office of Research and Statistics, Social Security Administration. Washington. U.S. Government Printing Office, Apr. 1981.

Ferry, T., Gornick, M., Newton, M., et al.: Physicians' charges under Medicare: Assignment rates and beneficiary liability. *Health Care Financing Review*. Vol. 1, No. 3. HCFA Pub. No. 03027. Office of Research and Demonstrations, Health Care Financing Administration. Washington. U.S. Government Printing Office, Winter 1980.

Fitzmaurice, J. M.: Office of Research and Demonstrations, Health Care Financing Administration. Personal communication, 1985.

Gibson, R., Levit, K., Lazenby, H., et al.: National health expenditures, 1983. *Health Care Financing Review*. Vol. 6, No. 2. HCFA Pub. No. 03195. Office of Research and Demonstrations, Health Care Financing Administration. Washington. U.S. Government Printing Office, Winter 1984.

Gornick, M., Ten years of Medicare: Impact on the covered population. *Social Security Bulletin*. Vol. 39, No. 7. SSA Pub. No. 76-11700. Office of Research and Statistics, Social Security Administration. Washington. U.S. Government Printing Office, July 1976.

Gornick, M., Hackerman, C., and Newton, M.: Factors affecting differences in Medicare reimbursements for physicians' services. *Health Care Financing Review*. Vol. 1, No. 4. HCFA Pub. No. 03045. Office of Research and Demonstrations, Health Care Financing Administration. Washington. U.S. Government Printing Office, Spring 1980.

Gornick, M.: Trends and regional variations in hospital use under Medicare. *Health Care Financing Review*. Vol. 3, No. 3. HCFA Pub. No. 03141. Office of Research and Demonstrations, Health Care Financing Administration. Washington. U.S. Government Printing Office, Mar. 1982.

Gornick, M., Beebe, J., and Prihoda, R.: Options for change under Medicare: Impact of a cap on catastrophic illness expense. *Health Care Financing Review*. Vol. 5, No. 1. HCFA Pub. No. 03154. Office of Research and Demonstrations, Health Care Financing Administration. Washington. U.S. Government Printing Office, Fall 1983.

Grad, S.: *Income of the Population 55 and Over, 1982*. SSA Pub. No. 13-11871. Office of Retirement and Survivors Insurance and Office of Policy. Washington. U.S. Government Printing Office, Mar. 1984.

Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the End-Stage Renal Disease Systems Branch, 1985.

Helbing, C., and Latta, V.: Office of Research and Demonstrations, Health Care Financing Administration. Personal communication, 1985.

Hill, I.: *Medicaid Eligibility: A Descriptive Report of OBRA, TEFRA, and DEFRA Provisions, and State Responses*. HCFA Contract No. 500-83-0058. Draft Report. Prepared for Health Care Financing Administration. Syracuse, N.Y. Center for Health Policy Research, National Governors' Association, Oct. 1984.

Jacobs, B., and Weissert, W.: Home equity financing of long-term care for the elderly. *Long-Term Care Financing and Delivery Systems: Exploring Some Alternatives*. Conference Proceedings. HCFA Pub. No. 03174. Office of Research and Demonstrations, Health Care Financing Administration. Washington. U.S. Government Printing Office, Jan. 1984.

Johnson, D.E.L.: Investor-owned chains continue expansion, 1985 Survey shows. *Modern Healthcare* 7 (12):75-90, June 7, 1985.

Kahn, A., and Rasberry, T.: *Program Demographic Characteristics of Supplemental Security Income Beneficiaries, December 1983*. SSA Pub. No. 13-11977. Office of Policy, Social Security Administration. Washington. U.S. Government Printing Office, Dec. 1984.

Kasper, J.: Perspectives on Health Care from the National Medical Care Utilization and Expenditure Survey, 1980. Draft Report. Office of Research and Demonstrations, Health Care Financing Administration. Baltimore, Md., 1985.

Kasper, J., and Howell, E.: Health Status of the Medicaid Population, National Medical Care Utilization and Expenditure Survey. Draft Report. Office of Research and Demonstrations, Health Care Financing Administration. Baltimore, Md., 1985.

Klarman, H.: Policies and local planning for health services. *Milbank Memorial Fund Quarterly* 54 (1):1-28, Winter 1966.

Krakauer, H., Hodges, J., Milam, R., et al.: Assessment of an Emerging Medical Technology, Cost Effectiveness of Cyclosporine in Renal Transplantation. Draft Report. Office of Research and Demonstrations, Health Care Financing Administration. Baltimore, Md., 1985.

Krute, A., and Burdette, M. E.: Prevalence of chronic disease, injury, and work disability. *Disability Survey 72: Disabled and Nondisabled Adults, A Mongraph.* Research Report No. 56. SSA Pub. No. 13-11812. Office of Research and Statistics, Social Security Administration. Washington. U.S. Government Printing Office, Apr. 1981.

Lave, J.: *Hospital Payment Under Medicare.* Proceedings of the Conference on the Future of Medicare. WMCP 98-23. Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives. Washington. U.S. Government Printing Office, Feb. 1, 1984.

Lazenby, H., and Waldo, D.: Division of National Cost Estimates, Office of the Actuary, Health Care Financing Administration. Personal communication, 1985.

Liu, K., and Petrie, J.: Study of Unentitled End-Stage Renal Disease Patients. Office of Research and Demonstrations, Health Care Financing Administration. Baltimore, Md., June 1984.

Long, S. H., and Settle, R. F.: Medicare and the disadvantaged elderly: Objectives and outcomes. *Milbank Memorial Fund Quarterly* 62(4):609-656, Fall 1984.

Lubitz, J., and Deacon, R.: The rise in the incidence of hospitalizations for the aged, 1967 to 1979. *Health Care Financing Review.* Vol. 3, No. 3. HCFA Pub. No. 03141. Office of Research and Demonstrations, Health Care Financing Administration. Washington. U.S. Government Printing Office, Mar. 1982.

Lubitz, J., and Pine, P.: Health Care Use by Medicare's Disabled Enrollees. Draft Report. Office of Research and Demonstrations, Health Care Financing Administration. Baltimore, Md., 1985.

Lubitz, J., and Prihoda, R.: Use and costs of Medicare services in the last 2 years of life. *Health Care Financing Review.* Vol. 5, No. 3. HCFA Pub. No. 03169. Office of Research and Demonstrations, Health Care Financing Administration. Washington. U.S. Government Printing Office, Spring 1984.

Macken, C.: Findings from the 1982 Long-Term Care Survey. Draft Report. Office of Research and Demonstrations, Health Care Financing Administration. Baltimore, Md., 1985.

McMillan, A., Pine, P., Gornick, M., et al.: A study of the "crossover population": Aged persons entitled to both Medicare and Medicaid. *Health Care Financing Review.* Vol. 4, No. 4. HCFA Pub. No. 03152. Office of Research and Demonstrations, Health Care Financing Administration. Washington. U.S. Government Printing Office, Summer 1983.

McMillan, A., and Gornick, M.: The dually entitled elderly Medicare and Medicaid population living in the community. *Health Care Financing Review.* Vol. 6, No. 2. HCFA Pub. No. 03195. Office of Research and Demonstrations, Health Care Financing Administration. Washington. U.S. Government Printing Office, Winter 1984.

McMillan, A., Lubitz, J., and Newton, M.: Trends in Medicare Physician Assignment Rates, 1968-1984. Draft Report. Office of Research and Demonstrations, Health Care Financing Administration. Baltimore, Md., 1985.

Mitchell, J. B., and Cromwell, J.: *Physician Behavior Under the Medicare Assignment Option.* HCFA Contract No. 500-78-0051. Prepared for Health Care Financing Administration. Chestnut Hill, Mass. Center for Health Economics Research, 1981.

Mueller, M. S., and Gibson, R. M.: Age differences in health care spending, fiscal year 1975. *Social Security Bulletin.* Vol. 39, No. 6. SSA Pub. No. 76-11700. Office of Research and Statistics, Social Security Administration. Washington. U.S. Government Printing Office, June 1976.

National Center for Health Statistics and Health Care Financing Administration: Data from the National Medical Care Utilization and Expenditure Survey, 1980.

National Center for Health Statistics and National Center for Health Services Research: Data from the National Medical Care and Expenditure Survey, 1977.

O'Brien, M., Rodgers, J., and Baugh, D.: Ethnic and Racial Patterns in Enrollment, Health Status, and Health Services Utilization in the Medicaid Population, National Medical Care Utilization and Expenditure Survey. Draft Report. Office of Research and Demonstrations, Health Care Financing Administration. Baltimore, Md., 1985.

Office of Family Assistance, Social Security Administration: Personal communication, 1985.

Packard, M.: Health status of new retired-worker beneficiaries: Findings from the new beneficiary survey. *Social Security Bulletin.* Vol. 48, No. 2. SSA Pub. No. 13-11700. Office of Policy and Office of Research, Statistics, and International Policy, Social Security Administration. Washington. U.S. Government Printing Office, Feb. 1985.

Pettengill, J.: Trends in hospital use by the aged. *Social Security Bulletin.* Vol. 35, No. 7. SSA Pub. No. 72-11700. Office of Research and Statistics, Social Security Administration. Washington. U.S. Government Printing Office, July 1972.

Rice, D. P., and Feldman, J. J.: Living longer in the United States: Demographic changes and health needs of the elderly. *Milbank Memorial Fund Quarterly* 61(3):362-396, Summer 1983.

Rice, T., and McCall, N.: Factors influencing physician assignment decisions under Medicare. *Inquiry* 20(1):45-56, Spring 1983.

Riley, G., Lubitz, J., Prihoda, R., et al.: Changes in the Distribution of Medicare Expenditures Among Aged Enrollees, 1969 to 1982. Working Paper No. 85-12. Office of Research and Demonstrations, Health Care Financing Administration. Baltimore, Md., 1985.

Ruther, M., and Dobson, A.: Equal treatment and unequal benefits: A reexamination of the use of Medicare services by race, 1967-1976. *Health Care Financing Review.* Vol. 1, No. 3. HCFA Pub. No. 03090. Office of Research and Demonstrations, Health Care Financing Administration. Washington. U.S. Government Printing Office, Winter 1981.

Rymer, M., Burwell, B., and Madigan, D.: *Short-Term Evaluation of Medicaid: Selected Issues.* Grants and Contracts Report. HCFA Pub. No. 03186. Office of Research and Demonstrations, Health Care Financing Administration. Washington. U.S. Government Printing Office, Oct. 1984.

Sawyer, D., Ruther, M., Pagan-Berlucchi, A., Muse, D. N.: *Medicare and Medicaid Data Book, 1983*. HCFA Pub. No. 03156. Office of Research and Demonstrations and Bureau of Data Management and Strategy, Health Care Financing Administration. Washington. U.S. Government Printing Office, Dec. 1983.

Scholen, K.: An overview of home equity conversion. *Long-Term Care Financing and Delivery Systems: Exploring Some Alternatives*. Conference Proceedings. HCFA Pub. No. 03174. Office of Research and Demonstrations, Health Care Financing Administration. Washington. U.S. Government Printing Office, Jan. 1984.

Scitovsky, A. A.: The high cost of dying: What do the data show? *Milbank Memorial Fund Quarterly* 62(4):591-604, Fall 1984.

Simanis, J.: Office of Research and Statistics, Social Security Administration. Personal communication, 1985.

Simanis, J., and Coleman, J.: Health care expenditures in nine industrialized countries, 1960-76. *Social Security Bulletin*. Vol. 43, No. 1. SSA Pub. No. 13-11700. Office of Research and Statistics, Social Security Administration. Washington. U.S. Government Printing Office, Jan. 1980.

Simmons, R. G.: Comparison of the Quality of Life of End-Stage Renal Disease Patients. Unpublished doctoral dissertation. University of Minnesota, 1985.

Social Security Administration: *Medicare: Health Insurance for the Aged, 1967*. Section 1, Summary. Office of Research and Statistics. Washington. U.S. Government Printing Office, 1971.

Social Security Administration: Data from the Survey of Disability and Work, 1978.

Social Security Administration: *Social Security Bulletin, Annual Statistical Supplement*. SSA Pub. No. 13-11700. Washington. U.S. Government Printing Office, 1983.

Social Security Administration: *Social Security Bulletin, Annual Statistical Supplement, 1984-85*. SSA Pub. No. 13-11700. In press.

Social Security Administration: *Aid to Families with Dependent Children*. Office of Family Assistance and Office of Policy and Evaluation. SSA Pub. No. 13-11731. Washington. U.S. Government Printing Office, Jan. 1985.

Stanley, G. L., and Swisher, I. G.: Medical care utilization by the disabled. *Social Security Survey of the Disabled: 1966*. Report No. 5. SSA Pub. No. 77-11713. Office of Research and Statistics, Social Security Administration. Washington. U.S. Government Printing Office, Jan. 1969.

U.S. Bureau of the Census: 1980 Census of Population, Persons in institutions and other group quarters. Vol. 2. *Subject Reports*. PC-80-2-4D. Washington. U.S. Government Printing Office, Apr. 1984.

U.S. Bureau of the Census: Personal communication on Current Population Survey, 1985.

U.S. General Accounting Office: *Changing Medicaid Formula Can Improve Distribution of Funds to States*. Report to the Congress. GAO/GGD-83-27. Gaithersburg, Md., Mar. 9, 1983.

U.S. Senate, Special Committee on Aging: *Medicare and the Health Costs of Older Americans: The Extent and Effects of Cost Sharing*. Washington, Apr. 1984.

Waldo, D., and Lazenby, H.: Demographic characteristics and health care use and expenditures by the aged in the United States: 1977-1984. *Health Care Financing Review*. Vol. 6, No. 1. HCFA Pub. No. 03176. Office of Research and Demonstrations, Health Care Financing Administration. Washington. U.S. Government Printing Office, Sept. 1984.

Walden, D., Wilensky, G., and Kasper, J.: Changes in health insurance status: Full-year and part-year coverage. *National Health Care Expenditures Study*. Data Preview 21. DHHS Publication No. (PHS) 85-3377. National Center for Health Services Research, Public Health Service. Washington. U.S. Government Printing Office, July 1985.

Weil, T.: Procompetition or more regulation? *Health Care Management Review* 10(3):27-35, Summer 1985.

Weinrobe, M.: Home equity conversion: Its practice today. *Long-Term Care Financing and Delivery Systems: Exploring Some Alternatives*. Conference Proceedings. HCFA Pub. No. 03174. Office of Research and Demonstrations, Health Care Financing Administration. Washington. U.S. Government Printing Office, Jan. 1984.

Wennberg, J. E., Barnes, B. A., and Subkoff, M.: Professional uncertainty and the problem of supplier-induced demand. *Soc Sci Med* 16(7):811-824, 1982.

Wilensky, G. R.: Solving uncompensated hospital care: Targeting the indigent and the uninsured. *Health Affairs* 3(4):50-62, Winter 1984.

blank page

Symposium

Introduction

The importance of the Medicare and Medicaid programs and the magnitude of their impact is perhaps unparalleled in the history of health care legislation. As a consequence of their importance and the role they play in health care financing and delivery, there is a strong public interest in assessing the Medicare and Medicaid programs as they exist today, and in gaining an informed perspective on the future directions they may take.

Our intent was to solicit ideas and opinions on four fundamental issues relating to Medicare and Medicaid from a group of individuals who were distinguished by their expertise and who represented a range of outlooks and viewpoints. Symposium participants were asked to focus on the same broad issues, providing us with their individual perspectives on these program issues.

The framework for the discussion of the issues follows. We asked them to address the impact of Medicare and Medicaid on beneficiaries, health care providers, and the government, and to consider implications for the future. For the first three issues, highlights of the salient features of the programs were noted. Then we raised a series of questions for the participants to consider in developing their responses.

Impact on beneficiaries

The primary goal of the Medicare and Medicaid programs was to reduce the financial barriers to access to health care services for the subgroups in the Nation with the greatest need for health care services and the least ability to pay for them. The programs were designed to enable the eligible populations to enter the mainstream of health care.

Medicare was established as a uniform federally administered program for persons 65 years of age or over, who were identified as having the greatest need for health care services, the least private health insurance coverage, and the least income to pay for services. Later, Medicare was expanded to cover two additional high-risk groups: the disabled under social security and persons with end-stage renal disease.

Medicaid was established to operate as a State-administered program under Federal guidelines and was designed to include aged poor, low-income blind, or disabled persons under age 65, and poor families with dependent children. In most cases, receipt of cash payments under one of the welfare programs means automatic eligibility for Medicaid. States have considerable freedom in setting income levels and conditions of eligibility and the latitude to provide coverage to "medically needy" persons who fit one of the categories covered by the cash assistance programs.

Medicare was designed to cover payments for acute-care hospital services, post-hospital extended care, outpatient care, and physicians' and related services. Under Medicaid, each State's plan must cover payments for certain basic services, including inpatient and outpatient hospital services, physicians' services, laboratory and X-ray services, and skilled nursing facility care for individuals 21 years of age or over, but States have latitude to establish the scope of benefits, the inclusion of optional ones, and the methods of paying for services.

Medicare was established with cost-sharing features for Part A and Part B, with physicians having the choice of accepting or rejecting assignment. Medicaid was established to provide the basic services to the categorically eligible without a cost-sharing requirement.

What do you see as the most important strengths and accomplishments of the Medicare program and what do you judge to be the most salient shortcomings affecting the beneficiary population in terms of access, quality of care, health status, and financial burden? . . . the Medicaid program?

How have program goals evolved and how have such changes affected beneficiaries over the past two decades?

What do you see as the major challenges faced by beneficiaries under the programs in the future?

Impact on health care providers

The Medicare and Medicaid programs were designed as service benefit programs. The Federal Government and State governments were placed in the role of insurers, guaranteeing payment for covered services to hospitals, physicians, and other providers of services.

Medicare adopted the practice of paying hospitals according to their costs, and physicians according to a customary, prevailing, and reasonable charge method. Fiscal agents were set up to deal with the health care providers, with the major responsibility for providing reimbursements and auditing services.

For the most part, Medicaid adopted the practice of paying hospitals according to the Medicare reimbursement principle. Physicians and other health care providers could be paid under different payment mechanisms.

Though enacted together, Medicare and Medicaid reflected different traditions; Medicare was part of the social security system, and Medicaid was part of the public assistance programs.

What do you see as the key decisions made in the design of each of the two programs with regard to the relationship between government as insurer and hospitals, physicians, and others as health care providers?

What have been the major impacts of the Medicare program on hospitals, physicians, and other providers of care in terms of costs, expansion, technology, education, financial structure, and organization? . . . the Medicaid program?

How have the impacts on the providers evolved over time? And how do you see the programs affecting providers in the future?

Impact on government

Medicare was designed as part of the social insurance system. The hospital insurance (HI) trust fund was established for acute-care hospital and extended-care services. An additional tax on the income of current workers was established to finance the HI system. The supplementary medical insurance (SMI) trust fund was established for the voluntary portion of Medicare that covers physicians and related services. The financing mechanism consisted of contributions from enrollees and the Federal general revenues. It was intended that enrollees would contribute 50 percent. Currently, enrollee contributions cover about 25 percent of outlays, and the Federal general revenues, the remaining 75 percent.

Medicaid is financed jointly by the States and the Federal Government. In some cases, local governments contribute. The Federal share, determined by a formula based on State per capita income, can range from 50 to 83 percent.

The States have altered Medicaid program characteristics over the years in terms of eligibility and benefits much more so than the Federal Government has altered Medicare.

What do you see as the key decisions that were made in the design of the Medicare program that shaped the impact (notably expenditures) on government? . . . the Medicaid program?

What are the key issues regarding the current financing methods? Under Medicare's Part A program, current workers participate in the pay-as-you-go system. Is this inter-generational transfer an effective financing method, or should the burden be shared differently, say by all age groups? If changes are made, how can the Federal Government "re-draw" the contract and maintain confidence and trust in the system?

Under Medicaid, should the burden be shared differently than it is now by the Federal and State governments?

What do you see as the strengths and weaknesses of a uniform federally administered Medicare program in contrast to the experience with State-administered and differing Medicaid programs?

What do you see as the strengths and weaknesses of the major strategies developed (e.g., regulation, competition, flexibility, and others) to implement future policies under the Medicare program? . . . the Medicaid program?

How does society decide on the appropriate share of the gross national product to devote to health care? Should the percentage be open ended? Or controlled by budgetary allocation? Will our health care system need to ration care?

Implications for the future

Many people think that we are at a "crossroads" with regard to the future directions of the Medicare and Medicaid programs. The aging of the population, the expected shifts in the population pyramid, the impact of the growth of medical technology, and the size of public expenditures—these issues and others—appear to many people to represent crucial problems that require some major actions now with regard to the Medicare and Medicaid programs.

Do you think the Nation is at a major "crossroads" with regard to the Medicare program? . . . the Medicaid program? If so, what direction should the Nation take?

Will concerns over expenditures necessarily curtail the access objectives of the programs?

Are there ways to modify the programs that would produce better results for the same or lower expenditures? Or do you recommend major revisions to the Medicare program? . . . the Medicaid program?

Are there lessons that our Nation can learn from the experience of other industrialized countries?

Are there new goals and new perspectives for us to adopt now and in the long run that would serve to strengthen the goal of assuring access to care for the poor, the disabled, and the aged?

Lonnie R. Bristow, M.D.

Dr. Bristow is an internist in private practice in San Pablo, California, with a subspecialty interest in occupational medicine. He has just completed 2 years as Chairman of the Council on Medical Service of the American Medical Association and was recently elected to the AMA Board of Trustees. A member of the National Academy of Sciences' Institute of Medicine and a past president of the American Society of Internal Medicine, he has written and lectured extensively during the past two decades about medical socioeconomics.

Impact on beneficiaries

There are great differences in the degree of public satisfaction with the Medicare and Medicaid programs, even though they have similar goals and at times overlap each other in program implementation. This is partly because of important differences in their beneficiary populations and partly because of substantial differences in the degree of Federal financial commitment to the two programs. These differences have affected the public's attitude towards these two programs in ways that should have been predictable.

The overwhelming majority of beneficiaries in the Medicare program spent most of their adult lives in productive employment. The group therefore comes from a socioeconomic stratum where individuals either already had, or managed to obtain, enough education, ability, and opportunity to lead to sustained employment. Those very resources also served to help them survive and, at times, avoid entirely the major health problem areas that attack and decimate the poor: childbirth, infectious diseases, and accidents and those cardiovascular, gastrointestinal, and mental illnesses that are often stress-related. These health problems really flourish in an environment of poor nutrition, educational deprivation, and environmental stress, and are both more devastating and recidivistic among low-income groups.

The Medicare population has gotten past those dangers and is instead faced with the major degenerative diseases: cancer, emphysema, and arteriosclerosis in all its various manifestations. The course of this latter group of illnesses is often surprisingly amenable to improvement both by lifestyle modification, if done early enough, and by therapeutic intervention when care is accessible. Such positive results are observed to be occurring in the Medicare population. Many individuals reaching their sixties today do not yet see themselves to be "old," although many of those in the Medicaid program consider themselves to be "burnt out" before the age of 35.

The other major difference is in the funding. Medicare is funded through a combination of Federal dollars and beneficiary dollars (for coinsurance, deductibles, and premiums) which, at least theoretically, ought to assure a little of the individual's vested interest in utilization decisions. Medicaid, however, is only partly Federally funded, with the remainder dependent on the ability and willingness of State legislatures to make discretionary commitments from their treasuries to carry out a Federal mandate. The result for Medicaid is a patchwork quilt of different approaches by each individual State towards limiting the scope of benefits in the program as the State seeks to meet the priorities of its own legislature. Health benefits for the poor have become intertwined with welfare benefits and are usually administered by the same department. In most States, the resulting financial commitment to the individual patient is substantially below that made to the individual Medicare patient.

Medicare beneficiaries have banded together in vocal unity, finding financial and political strength, but the needs and perspectives of the Medicaid patient are not well articulated by the group. Such organizations as they have are not as well financed, as cohesive, or as effective—quite possibly for the very reasons stated earlier.

The stage therefore was set for the public to eventually see the Medicare program as a "medically successful" albeit costly effort. However, the public has felt a gnawing dissatisfaction with the Medicaid program, because expenditures that were grudgingly budgeted to begin with have not yielded similarly enhanced health outcomes. American society must understand the limited ability of the health care system alone to permanently impact the core problems of inadequate nutrition, education, and economic opportunity. The "preventive medicine" for those problems cannot be found in lifestyle changes or on the pharmacy shelf. Therefore, Medicare and Medicaid should never have their success or failure measured by yardsticks that do not adequately allow for these two major differences in the programs and populations served.

The Medicare program clearly has been immensely successful, not only in increasing access to basic care, but also to care of a high quality. This is because it drastically reduced economic barriers which previously existed for many. Before the enactment of the Medicare law, there was very little private health insurance available for those who were over the age of 65 and not employed. As a result of several factors, our Nation's population now enjoys significantly increased longevity. Life expectancy has increased from 70.2 years in 1965, when the law was enacted, to 74.4 years in 1983. These are the basic strengths and accomplishments of the Medicare program, and they are substantial.

All health care providers have risen in public esteem to the degree that medical care is seen to have contributed increased longevity. With this higher esteem, however, has come additional demand for these apparently valuable medical services. A serious shortcoming in the Medicare program was the failure of the original architects and builders to adequately forecast what the realistic funding requirements would be in the future. They also did not foresee the explosion in technologic medical knowledge or recognize the inherent danger of having a program whose beneficiary eligibility could be so easily modified by the whim of the Congress. It is understandable that they tried to use a flat payroll tax (with a cap) as a means of insulating the program from the effects of long-term changes in our Nation's economy. That may have been an attempt to use insurance concepts for the program. Unfortunately, this was later eroded when Congress wanted to find a "painless" way to fund health care for the totally and permanently disabled. Conveniently, the Medicare program was there. This was followed during a boom economy by adding on the end-stage renal disease program by a Congress that was sensitive to pressure groups.

The Medicaid program has attempted to bring the poor into the "mainstream" of the health care system. It clearly did improve access to high quality care for about 15 years. However, that progress has been progressively eroded during the last few years because of a receding fiscal base of support in States that do not have the same luxury of sustained deficit budgeting as enjoyed by the Federal Government. For all of its encumbrances, the Medicaid program has had definite impact in improving the national survival rates of both mother and child in full-term pregnancies. Unfortunately, the gap between the poor and the affluent is still unacceptably large and will predictably increase with the projected Federal budget cuts in maternal and child health care programs.

No one could predict that, for more than a decade, successive Presidents and Congresses would create consecutive deficit Federal budgets which, combined with an energy crunch in later years, has lead to the current fiscal crisis of today. That crisis is directly responsible for the two major challenges to both the Medicaid and Medicare programs. Both groups must fight the threat of reduced benefits as cost savings measures on the one hand, while each simultaneously works to encourage the more efficient use of the system by their unique group of beneficiaries. As alluded to earlier, Medicaid beneficiaries have a muted voice, which adds to their difficulties in this political struggle.

Impact on health care providers

As far as providers are concerned, the choice of precisely how the hospital was to be paid has turned out to be easily the most pivotal decision in the design of both the Medicare and Medicaid programs. Evidently, the designers did not foresee the grossly inflationary and ultimately harmful effect on health care costs that would result from the decision to pay hospitals on a cost-only basis. Probably in innocence, the position was taken that it would be wrong for an institution to profit from providing care for the elderly. If the designers had prepared an environmental impact study at the time, they might have come to understand that institutions often act just like individuals; when there is no incentive or capability to make a profit, there is often virtually no incentive to be efficient. If a hospital with a large percentage of its patient population covered by Federal funds had to choose between getting a manual typewriter, an electric typewriter, or a word processor, they soon learned to choose the word processor. The design of the system told them costs were all they were going to get from the transaction, so they might as well go first class. The cost-based reimbursement of hospitals became the engine that drove health care costs beyond anyone's wildest projections. Thus, review of Medical Care Price Index data (which used 1950 as the index year for plotting subsequent changes) shows that between 1965 and 1975 (the first decade after the Medicare law was enacted) physician fees in this Nation rose by 12 percent. During the same timeframe, hospital semi-private rooms rates rose by 171 percent. Understandably, the rate of escalation of overall costs has attracted public attention. Because Medicaid, for the most part, has also paid hospitals according to the Medicare reimbursement principle, it has come under the same jaundiced eye of concern.

The customary, prevailing, and reasonable (CPR) method of deciding the amount Government is willing to pay for physician services under Medicare was designed to assure access to the wide spectrum of physician skills that specialization and new technologies have brought us. The CPR method was roughly patterned after the usual, customary, and reasonable (UCR) concept developed more than a decade earlier to help certain private insurers in determining if a specific fee was excessive or not. The unadulterated concept of UCR, as originally devised, was relatively faultless. Several modifications occurred on the way to the CPR method of deciding payment amounts, but a close resemblance to the UCR concept was retained. However, a problem developed when the private insurance industry stepped in and began to offer Medigap coverage. This assured first-dollar coverage and, unwittingly, effectively removed the patient from the payment transaction. No one who made health policy at the time thought this was too important, but any practicing physician can tell you that discussing the fee with a patient on a face-to-face basis tends to have an important modulating effect that is totally absent when one is billing a distant third party. Without that modulating effect, an inflationary trend has prevailed, adding a booster rocket to the engine of rapid cost escalation.

The Medicare program has also been a boon to the further development and spread of specialization in medicine and health technology. However, what started as the tail is now wagging the dog. Government programs collectively have now become the single dominant insurer for adult health care in America. Because of concern about their growing costs, Government program managers initially sought more and more regulatory controls to bridle those costs. Although the effect of these controls is still debated, the majority opinion seems to be that regulation has not worked. Regulation could probably never simultaneously deliver both high quality care and the "right" cost because it tends to stifle creativity. Many physicians giving care today have come into the system within the last 20 years and have never known any other way. It is predictable that any change in the system will be difficult for many of them to understand, and accommodation may not be easy.

As these programs change in the future, they will almost surely establish the path in which private-sector-financed health care will follow. Just as access and quality can have a substantial impact on cost, the reverse is equally true; efforts at cost control have a like potential for influencing access and quality. Those providers of care who seek to find continued personal satisfaction and excellence in their work will need to have adaptability. The great danger for all parties, however, is that concerns about cost could express themselves in sufficient "carrots and/or sticks" to drive physicians into a retreat from professionalism. Their credo must always be "healing first and profit second." National deficit spending because of defense and energy priorities, however, is now creating tremendous social and economic pressure on that credo, driving it towards a concern about dollars first and healing second.

Involving the greater society in a more equitable sharing of the financial burden of caring for the poor under Medicaid was certainly a plus, but an important side issue here is that Government also specifically introduced the concept of entitlement to health care funding based on age alone rather than the ability to pay. Many senior citizens who would have experienced no financial hardships in purchasing health insurance, if it had been made *available* before 1965, now have that availability, but they also have their care largely paid for by younger generations who are still working. A political gift has been made to both the needy and the self-sufficient, and I feel we have crossed a threshold over which there is no easy retreat.

Impact on government

Two critical decision points occurred in both the Medicare and Medicaid programs that affected our Government significantly economically and indelibly sociologically. The first, common to both programs, was the decision by Government to use the cost-based approach as the basis for payment of hospitals. This approach simultaneously destroyed opportunity for hospitals to profit from their services and removed their incentive for efficiency. This also created the propulsion system that drove health care costs inexorably upward. More important, hospital administrators were diverted from competition with each other to the new objective of attaining maximal flow of these "nonfat, zero-calorie" Federal dollars.

The other critical decision point in the two programs happened to be entirely different for each, and in neither instance did Government offer a definitive answer to the problem.

In the Medicare program a problem arose because of a decision by the private insurers to enter the picture and offer Medigap coverage. This provided first-dollar coverage and effectively removed many patients from having significant concern about the cost of physician services. This proved to be another inflationary stimulus, gradually adding to Government's financial concerns. Government did not address this in any direct fashion, thus giving up one of the original build-in checks and balances in the program. This might be called an example of a nondecision.

On the Medicaid side, the second critical point was probably the failure to sustain President Lyndon B. Johnson's War on Poverty, which was the only attempt of our country to confront the core issues of why Americans have an economically poor segment of our population. That program, and its successors, have fallen victim to other priorities. Even the finest health care system in the world (which I consider to be the case here in America) cannot provide adequate nutrition, education, and economic opportunity out of the doctor's house-call bag. Unless that prescription for the Nation is filled, those health care needs unique to the poor will continue to exist and probably increase in size.

The key issues now facing Government for the Medicare program are, on the one hand, the lack of predictability for overall Federal costs each year and, on the other hand, the fiscally unsound manner in which the Part A program is currently funded. The transfer of funds across generations is robbing-Peter-to-pay-Paul economics at its worst, and it has come to be recognized for what it is—a growing percentage of elderly citizens receiving health care that is largely paid for by a correspondingly dwindling percentage of workers.

A major flaw in the current Medicaid program is the unevenness from one State to another of the health care benefits to which beneficiaries have access. A strong case can be made, particularly in the Medicaid program, that inadequately funded health care is actually significantly more expensive, in the long run, to the Nation as a whole. Inadequate funding leads to suboptimal outcomes which have their own costs to the Nation, not only in mortality and morbidity, but also in lost economic and creative productivity. America must have the vision to realize this is not a guns versus butter issue. We have not been "saving" in the overall sense, because the eventual total cost in resources has been much greater than the sterile dollar estimates usually made by statisticians.

As with many other things in life, health care services done well and promptly are far more cost effective than any other alternative. This means the health benefits package in Medicaid must become both adequate, as defined by the American Medical Association in 1983, as well as uniform across the country. In its first term, the Reagan Administration made clear its desire to see welfare program funding shifted to the States. Whether a national uniform health benefits package for the poor that is truly adequate can be mandated within the confines of the Reagan goals remains to be seen. Until now, the individual State's contribution to the funding of health care under Medicaid has been according to its estimate of its ability to pay. The program's dependency on that concept no longer seems practical.

Whatever future form these programs take, they must have administrators and here there is clearly room for improvement. I believe the private insurance industry is far more capable than Government to function as administrators of a health insurance program. If the public and health care providers can be assured that these health insurance programs would contain, as a minimum, the health insurance package of adequate benefits as defined by the American Medical Association in 1983, a voucher system would clearly lead to great economies and, simultaneously, take Government out of the insurance business.

For four decades, the hallmark of American medicine has been creativity and innovation. Thirty years ago this past April, the Salk vaccine passed its last tests and was released for public consumption. A Nation of approximately 165 million was enduring 55,000 new cases of paralytic polio every year. Overnight that changed, and today the Nation has less than 20 new cases each year, thanks to creative genius.

Regulation can never work as a cost-containment tool in the provision of high quality health care. Under regulation, creative energy, if not stifled, tends largely to be channeled into trying to circumvent this regulation. Health care needs are far too individualistic to be determined by any single inflexible agency. Every individual has priorities that are unique to that person at any particular point in his or her life: education, recreation, family, religion, housing, etc. Health care must find its place among many items, and the amount of personal resources that should be committed will vary in a personal way. Hence, a variety of options must be available. Society will only know the appropriate share of the gross national product to devote to health care when it not only allows, but encourages, involvement of patients in health care decisionmaking for themselves. This is best done by allowing a modest amount of cost sharing in all decisions by those who can afford to pay for their health care. The cost-sharing amount should ordinarily not be enough to prohibit an individual from having the service so much as to simply sensitize and make the person interested in the cost of health care decisions. Conversely, for those who cannot afford to pay for care, positive incentives consisting of rewards for good decisionmaking should be used. In my opinion, the use of penalties for poor decisionmaking by the indigent simply does not work and is self-defeating in the long run.

Returning to the subject of those who can afford to pay for care, the question of how much should the American public pay for health care is often raised. Where any third party (Government or insurance entity) is involved as a fiscal agent, all it needs do is determine how much is the maximum its program will pay for specific services, based on its available premium resources and a reasonable projection of what is the expected pattern of utilization. Any difference between what the third party determines to be the maximum sum payable for a given service and what the health provider charges should be open to discussion and negotiation between the patient and the health care provider. Obviously, people have to have the opportunity to know what those charges are likely to be before they agree to have the service. That is essential. If these concepts are adhered to, there will be no need for care to be artificially "rationed". At the same time, each third party will have the predictable outlay it desires, and Government will have the answer to its conundrum of "What is the appropriate share of the gross national product to go to health services?"

Implications for the future

We have a growing national budgetary crisis that has been fueled by many other, often larger, factors than health care costs. Nevertheless, largely because of this, health care financing is already undergoing change. It will doubtless experience more change in their near term. With change there are rather obvious dangers, but change also provides an opportunity for creativity.

Entitlement by age as a concept has been sold politically to our electorate and is undoubtedly here to stay, but it must be made fiscally sound. If we are to continue the concept of entitlement by a defined age, then eventually each group achieving that age must have paid its way, but based on each individual's ability to pay. There are already a large number of individuals operating under the old social contract, and any change that occurs must be phased in (with the funding mechanism of the old contract simultaneously being gradually phased out) over a period of time. This would require a minimum of two, perhaps three, decades. Since the new entitlement approach I am suggesting would also apply to everyone based on age, there can be no opting out of this new system either. All must pay as they go along, but contributions would be targeted to fund the needs of each specific age group. In the meantime, until the existing Medicare program is phased out, its source of funding should remain basically as is. As one progam is phased in and the other is phased out, there will necessarily be a dovetailing in sources of funding, but the benefit package should remain the same. This can be worked out both actuarially and politically.

Two important additional points should be made when thinking of how we address the future. They concern the Federal commitment to education and to the poor.

Medicare has been an important source of funding for residency training programs. As a practicing physician, I can identify with the desire to see patient care funds targeted to result in more benefit to patients. I recognize the common perception that medical education costs are somehow more beneficial to physicians than the patients they serve. Although I cannot quantitate it, I know the scales have been improperly balanced. House staff training programs have always given back significant advances in medical knowledge far more often then they are credited for. Let me give just two brief examples. Few people know that the entire field of cardiac enzyme analysis to detect a myocardial infarction was initiated by the ingenious seminal work of an American resident physician, Arthur Karmen. His work with the serum transaminase enzyme opened a doorway of information ultimately benefiting millions of people around the world. His only significant reward was that for a few years the SGOT (serum glutamic oxalacetic transaminase) was measured in Karmen units; then "international units" supplanted his name in the terminology. In the early 1970's, another American resident physician, Bergein Overholt, was the first person to use a colonoscope with flexible fiberoptics on a human being. That development has since spared hundreds of thousands of patients around the world of the need for major abdominal surgery in instances now manageable by the colonoscopic approach. One could list many more instances; the point is that there has been, and continues to be, substantial public benefit from residency and fellowship training programs. These benefits go beyond the patient care rendered, but this reality has not been recognized by the public. Shifts in the funding of medical education will undoubtedly occur but, before they occur, reasonable and rational efforts must be made to replace that funding. Much more is at stake than simply the direct patient care rendered.

As we move into the future, I hope it will be with wisdom gained from our past. I have touched on the experience of the Medicaid program and dwelled not unduly on its inadequacies. There is good reason for every American to view those inadequacies with concern. The economic experiences of the last 5 years have shown many middle-income Americans that they are not as insulated and secure as they once believed. Many should realize they are really only two, or perhaps three, paychecks away from welfare themselves.

The original goal of increasing access for the two defined populations was, and continues to be, worthy. We have seen flaws develop, as must occur in every human endeavor, however, as a Nation, we now have a base on which to build while we correct the flaws. We should carefully assess what has occurred in other industrialized countries, both the good and the bad, although we should not lose sight of the important differences in culture and resources that can make transplanting of ideas quite hazardous. Most important, it is not idle jingoism to say health care in America is more effective today than that rendered anywhere else in the world. As we make needed adjustments, we should ensure that we protect what we have already achieved.

We have finally moved away from cost-based payment for hospitals, but prospective pricing for hospitals is not, and should never be considered as, an end point because it only moves Government over into a different version of the regulation game. We should recognize that our objective must be to move towards a true market concept where the beneficiary has an opportunity to know enough about both the product and the providers to be selective, and has a vested interest in making prudent decisions. The public must have, as much as possible, access to enough information about hospital prices and physician fees to make an informed choice. Such information must be made easily available, but in a way that recognizes both the dignity of the professional and also the right of the patient to know.

Even with better-informed, economically sensitive beneficiaries and providers, the funding of both programs will still need to be changed, as I have suggested earlier, to make them fiscally sound for Medicare, and socially equitable for Medicaid. With positive incentives for all parties, it is possible to achieve efficiency and yet maintain individual freedom. That would be a goal worthy of our unique national heritage.

blank page

Michael D. Bromberg, Esq.

Michael D. Bromberg is Executive Director of the Federation of American Hospitals. Before joining the Federation as Director of the Washington Office in 1969, he was legislative and administrative assistant to former Congressman Herbert Tenzer. Mr. Bromberg graduated from Columbia College, and received his Bachelor of Laws degree from New York University Law School. He is a member of the Bars of New York State, the District of Columbia, and the U.S. Supreme Court, and an adjunct professor of health policy at Duke University's Institute of Policy Science and Public Affairs.

Impact on beneficiaries

"Everything begins in sentiment and assumption and finds its issue in political action and institutions." Lionel Trilling's remark is especially apropos to Medicare and Medicaid. These two programs began with utopian sentiments and assumptions of unlimited resources. The vocabulary of unconditional entitlement is still used, but other themes, stressing individual responsibility and entitlement based on means, are becoming more prominent. In general, overly optimistic assumptions have been replaced with a realistic sense of fiscal limits.

The new realism is forcing a recognition that major reforms are necessary. It is both morally and economically unacceptable to burden future generations with our health care bills. Adding to our children's and grandchildren's debt without adding to their inheritance is like trying to get something for nothing without the other person's consent. Yet, people who became eligible for Medicare in 1983, for example, will receive between 6 and 25 times as much in Medicare benefits as they contributed (Health Care Financing Administration, 1983). The ratio of people's contributions to Medicare payments in their behalf will probably rise as more people spend their working lives paying into Medicare; but, even under rosy projections, current generations will be getting more than they give.

Although Medicare beneficiaries today have access to high quality health care, many would argue that they do not receive the best value per health care dollar spent; for some elderly, out-of-pocket health care spending is still a high proportion of income. The social contracts between society and Medicare beneficiaries and Medicaid eligibles need modification as does the way health care to the elderly is financed.

Granting that basic changes in the sentiments of beneficiaries, providers, and Government are vital, there is nevertheless ample gestation time for the creation of new institutional arrangements. According to the latest projections from the trustees of the hospital insurance trust fund, it is not likely to go into deficit until late this century or early the next (Health Care Financing Administration, 1985).

Medicare has been a brillant success in lowering financial barriers to access to health care services. Since its inception, the percent of people 65 years of age and over using the hospital has risen significantly (Lubitz and Deacon, 1982); about one-third of the Nation's health care spending today is for people 65 years of age and over, up from less than one-quarter in 1965 (Fuchs, 1984). These clearly are indicators of success.

Because funds available to pay for the aged's health care over the long run appear likely to fall well short of projected demand, rationing is inevitable. There are two fundamentally opposing rationing principles. One is the egalitarian: If everyone cannot have a certain kind or level of service, then no one should. The other is what I call the humane pluralism principle that:

- Guarantees everybody both access to good care and freedom from the fear of financial devastation by catastrophic illness.
- Gives precedence in public programs to the less fortunate.
- Requires greater self-reliance of the more fortunate.
- Puts a high value on a wide variety of health plan choice and, therefore, tolerates many different health care systems with access to care, above what Government payments will buy, subject to ability to pay.

I advocate reliance on humane pluralism for several reasons. First, it best promotes that level and mix of health spending that will give Medicare beneficiaries the best possible health care for the dollar. With a pluralistic rationing system, millions of beneficiaries will be searching for the best buys in health care coverage. This process will reveal the best value versus cost tradeoffs far faster and better than the central rationing authority that would be required under the egalitarian principle. Second, adoption of the egalitarian approach in a democrary that exalts individual rights is almost certain to overburden future generations. If each person wants more but can only have it if everyone has equal access, then the pressure on politicians will be overwhelming to offer a new benefit and let future generations worry about how to pay the bills. Third, if authority to make rationing decisions with life or death implications were concentrated in our political institutions, the respect, trust, and affection politicians must have to govern well would be weakened. Who wants leaders who feel comfortable denying care because it is too expensive?

If adaptation to the need to ration is based on the pluralism principle, the following changes affecting beneficiary participation in financing their own health care would be fitting:

- Medicare would assure that the minimum benefits guaranteed to all beneficiaries would include coverage for the costs of catastrophic illness. Besides relieving the aged of the worry that catastrophic illness will leave them destitute, this reform would significantly reduce beneficiary confusion as to what is covered. To the extent that this feature would require additional outlays, it could be financed by an income-related premium surcharge. Actuarial analysis indicates that the extra cost per enrollee would not be prohibitive (Gornick, Beebe, and Prihoda, 1983).
- The noncontributed portion of the average annual Medicare cost per beneficiary would be included in the calculation of taxable income for Medicare beneficiaries (aged only). To avoid double taxation of beneficiaries, the amount added to taxable income would have an equal Medicare's per beneficiary cost multiplied by the percent of payments to the hospital insurance trust fund and the supplemental medical insurance trust fund *not* financed by employees directly. (Adjustments like those made to social security would be necessary to avoid taxing Medicare contributions in behalf of people with low incomes.) In an era of huge budget deficits, it makes little sense to excuse the affluent elderly from the societal obligation to assure that the financially stressed elderly have access to good care.
- Eligibility for Medicare should be raised to 67 years of age over a multi-year period so that it eventually conforms with eligibility for social security. To assure that people 65 years of age or over have the opportunity to be productively employed and therefore self-reliant, this reform should be accompanied by more flexible arrangments as to wages, benefits, and hours of work. Given the increase in life expectancy, a new definition of old age seems in order. In 1935, when the social security program was born, life expectancy at age 65 was 12.5 years. By 1982, life expectancy at age 65 had increased to 16.8 years (Waldo and Lazenby, 1984).
- To preserve beneficiary choice, beneficiaries must have the right to pay health plans extra if they want a higher level of service than could be offered at the Government payment rate.
- There should be an inquiry into the desirability and feasibility of asking each generation to take responsibility for financing its own retirement health care needs. Specifically, thought should be given to establishing, over the long run, a link—not by individual but by age cohort—between funds contributed by and for Medicare beneficiaries during their working years and funds made available by Medicare for health care coverage during their retirement.

The enactment of Medicaid represented society's recognition that financial barriers to adequate health services ought to be removed and the cost borne by all taxpayers. For the poor, this program has been a huge success. Per capita visits to physicians and other health providers by low-income individuals have increased dramatically (National Center for Health Statistics, 1984).

The failures of the Medicaid program are directly related to the fact that there are 49 State programs with widely varying income eligibility and coverage provisions. As a result, there is no national eligibility floor, and access to governmental assistance for health services is denied to many near poor and medically disadvantaged Americans. Those individuals who remain uninsured form a large block of our population known as indigents in health care terminology; until society defines its commitment to them, our national health policy will remain incomplete and unsatisfactory. The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1983) questioned the logic of national policy that subsidizes employer-paid health insurance through the income-tax exclusion while spending substantially less on health programs for the poor. The Commission said, "This pattern of care is difficult to justify from an ethical standpoint. There seems to be little reason for such Government assistance to middle- and upper-income individuals, most of whom could take financial responsibility for their own care . . . without undue hardship."

As the States attempt to make more cost-effective use of their Medicaid funds, the major challenge to Medicaid eligibles will be to maintain access to adequate quality of care as their freedom of choice to select providers is necessarily restricted. Alternative health plans will be utilized increasingly by State governments to fix a capitated price per eligible for total health care. We can and must assure that quality is assured as that shift to restricted freedom of choice occurs.

Impact on health care providers

The key features of Medicare's payments to providers have been service-specific payment, different coverage for different services, reasonable charge-based payment to physicians, and, until 1983, retrospective, cost-based payment to hospitals. The defects of Medicare's payment system are serious and well known, but we should not forget that it did what it was originally designed to do very well. No other form of payment would have spawned so rapid an increase in the availability of state-of-the-art care for acute illness. Whatever else it did, Medicare gave a powerful boost to the spread of new technology and to an upgrading of the Nation's hospital plant and equipment.

Although Medicare's payment system was suitable for an era dedicated to greater access, it is not appropriate today. When there is not enough money to meet everybody's perceived needs, a focus on productivity must be paramount. However, the incentives inherent in Medicare's coverage and payment policies remain at odds with the behavior needed to deliver the best care possible per available dollar. The completeness of insurance coverage varies greatly and payments are service-specific rather than patient-specific, i.e., capitation based. A fragmented payment system means that it is in no one's interest to manage the course of a patient's care from prevention to treatment so as to provide high quality at minimum cost. The care that would produce the best health outcome per dollar almost never is the same as the mix and level of care that maximizes reimbursement. This arrangement condemns Government and providers to an unending battle over the appropriateness of care with the best judges—the beneficiary and his physician—remaining on the sidelines.

With Medicare's introduction of its prospective payment system, the conflict between provider incentives and Medicare's goals was diminished. By cutting the link between cost and payment, Medicare's prospective payment system forces hospitals and physicians to strike a balance between the patient's interest in having the best of everything and society's interest in containing costs. Besides substituting cost-cutting incentives for cost-increasing incentives per case, prospective payment also has forced physicians and hospitals to work together as an economic unit. This cooperation is a prerequisite for delivery of better care at less cost.

Although an improvement over cost-based reimbursement, prosective payment itself must be replaced if further progress is to be made toward better quality per Medicare dollar. Prospective payment has all the defects of a centrally administered pricing system. The variety of local supply and demand conditions for both hospital inputs and outputs is, for all practical purposes, limitless. Thus, no general rules (necessarily based on averages) will appropriately account for the specific circumstances of many and perhaps most hospitals. On the other hand, it is impossible for the Health Care Financing Administration (HCFA) to collect the information needed to set prices properly for several thousand hospitals. Even if HCFA could set prices just right at one point in time, it could not adjust to changes fast enough to avoid large arbitrary shortfalls and windfalls.

Because Medicare, as often as not, will miss the mark, it will be subject to intense, unending pressure to grant exceptions. The process of adjustment will become increasingly politicized, and adjustments will become increasingly remote from what is necessary to set prices at the right level, as close as possible to individual hospital long-run average costs. Winners will keep quiet. Losers, almost always having legitimate reasons for complaint, will petition vigorously. Over time, the exceptions will become the program; both hospitals and Government will be entangled in an ever-spreading regulatory snarl, characterized by costly and time-consuming administrative and judicial appeals.

The losers will be not only politically weak hospitals, but Medicare beneficiaries and taxpayers as well. Medicare enrollees benefit the most and taxpayers get the most productive use of their dollars if hospitals have to compete for patients, with the biggest share going to those hospitals that, in the perception of patients and their physicians, provide the best care per dollar available. By contrast, under prospective payment, Medicare payments to hospitals are allocated by bureaucrats and politicians. The result is misallocation and inefficiency. This happens not because of the lack of competence or good will. It occurs because of lack of information and the fact that the hospital groups with the most political power are not necessarily the ones that would win in a competition where physicians and patients are the judges.

If Medicare is to contain costs while still meeting beneficiary expectations for quality and access, I believe a two-track strategy is necessary. In the short term, payment rates should be adjusted to better reflect factors affecting a hospital's costs but beyond its control. To minimize arguments over fairness and to make the greatest possible progress toward this goal in the least amount of time, HCFA needs an adjustment measure that meets two tests:

- It is based on objective, replicable measures whose variations are strongly associated with patient cost variations.
- It accounts for the biggest part of the difference between the current payment rate and the rate that would fully, but exclusively, reflect cost-influencing factors beyond the hospital's control.

A severity measure (if one could be developed in a reasonable amount of time) would best meet these tests. Recent research (Brewster, 1984 a and b) indicates a high association between severity and cost; the addition of some severity adjustment, even though not a perfect one, might do more to account for uncontrollable cost-influencing factors than anything else. Since factors such as bed size, urban area population, and proportion of low-income patients served are useful mainly as proxies for patient health status, the adjustment of payment rates by a direct measure of health status might make the need to use such proxies moot.

Long-term, fixed price should supplant a la carte. Specifically, HCFA's fragmented, service-specific payment system should be replaced with a fixed payment per year to a health plan of a beneficiary's choice. All plans would be required to cover a specified set of services, including catastrophic coverage. Beneficiaries should be allowed to keep the difference between the per beneficiary amount and the actual amount charged by the private health plan. Conversely, if Medicare beneficiaries wanted a more generous health insurance package than the fixed Government payment would buy, they would have to pay the difference.

The advantages of a capitation approach with providers at financial risk are compelling:

- Providers would have the flexibility and the incentive both to minimize cost per unit of service and to find for each patient the most efficient mix of services.

- No longer would providers find a conflict between the mix of services that paid the most and the mix that provided the most cost-effective care; nor would they have an incentive to increase the volume of services.
- Problems with either the total cost or the quality of any aspect of a patient's care would be more rapidly identified and remedied because accountability for both the cost and quality of health care would be combined and therefore much more focused. One organization would be at financial risk for the total cost of covered services and solely responsible for their qualilty.
- Beneficiary paperwork and confusion over what was covered would be minimized.
- By offering beneficiaries a much greater choice among health plans, Medicare would better accommodate individual beneficiary preferences.
- Perhaps most important, rationing decisions would be decentralized. Above a mandatory minimum level of coverage, health plans would be free to compete according to different coverages as well as by price. Difficult decisions as to who should be covered for what, above certain societally mandated minimums, would be decentralized and depoliticized. The unavoidable process of making painful rationing decisions would devolve to those people best qualified to make them.

Although I believe that capitation-based payment is clearly superior, there are implementation problems. The most serious are the related problems of adverse selection and the setting of capitation rates. Adverse selection occurs when, by provider design and/or by consumer choice, people likely to be above average users of health care services are concentrated in a few plans. Adverse selection would not be that serious a difficulty if fixed Government capitation payments could be set accurately to reflect the cost of each patient's expected usage, given his or her health status upon entering a health plan or renewing participation. The technology needed to identify high-cost users in advance, however, is not well developed. The capitation rate-setting process would also be plagued with many of the same problems besetting the prospective payment program, e.g., how to measure and account for uncontrollable cost-influencing factors in addition to patient health status.

No one knows the dimensions of these issues:

- How serious the adverse selection problem really is.
- How popular capitation payment will be with Medicare beneficiaries.
- How to provide for good quality control, adequate patient information, a smooth transition from the current payment system, and adequate policing to assure that health plans compete on price and quality dimensions, not on who can best avoid the sick.

Given our ignorance and the great potential advantages of capitation payment, HCFA should concentrate its research and demonstration program efforts on finding answers to these capitation-related issues.

Ultimately, the choice between capitation or a much more regulatory approach to Medicare payment will turn not on technical issues but on a political judgment: Do we want to concentrate or decentralize the process of deciding how to reconcile the patient's interest in the best of everything with society's interest in containing costs? With concentration, providers will have to accept a higher level of coercion than they are used to and the range of available treatments will be narrowed. With decentralization, society will have to be willing to accept many different levels of care with access to exotic but expensive new treatments partially dependent on income.

The limited State resources devoted to Medicaid providers have reduced the pool of physicians and other providers willing to serve this population. There is an opportunity to remedy this situation and stimulate price competition among groups of providers by encouraging alternative health plans to bid for government contracts to deliver health care at a fixed price to Medicaid eligibles. As these alternative health plans mature as contractors with private employers and the Medicare program, their services can be utilized by State Medicaid programs to lower costs through health prevention and maintenance, utilization controls, and integrated management.

Impact on government

If the decentralizing strategy I propose is to deliver its promised benefits, Government must design and enforce rules to assure that the markets for health plans are properly structured so that there is maximum feasible competition of the right kind. Government must, at minimum, do the following:

- Mandate the collection and dissemination of the information required for Medicare beneficiaries to make intelligent choices as to which plan best fits their needs.
- Enforce antitrust laws.
- Minimize both the temptation and the opportunity for providers to compete by shunning sick patients.
- Establish a single basic Medicare benefits package that all American eligible for Medicare will have access to regardless of financial circumstances.
- Provide for the protection of beneficiaries of plans that cannot or will not meet their commitments.
- Act as agent for those beneficiaries who cannot make their own choices and who do not have family.

For Medicaid, the differing programs resulting from State administration illustrate a weakness in terms of economic eligibility and national policy, but they provide certain strengths in terms of allowing innovations and testing the cost effectiveness of different delivery systems.

Implications for the future

Besides designing and enforcing rules to assure vigorous competition of the right kind, price and quality, Government also has a role in financing health care services whose collective benefits are great, but which would not be produced in private markets because suppliers could not appropriate enough of the value created to make their efforts worthwhile. Care for the indigent, most kinds of research, and, arguably, medical education are examples of health services that require subsidy. The problem is how to subsidize these services. Currently, Medicare subsidizes teaching and research indirectly through its payments from the hospital insurance trust fund. With an indirect subsidy, nobody is quite sure who is getting how much money and what is being done with it. Teaching, research, and indigent care especially should be financed by Government, but by direct appropriation. A direct subsidy makes recipients much more accountable to public officials. The seperation of payment for teaching and research from payment for patient care also will make it easier to compare teaching hospital performance with that of its competitors according to criteria most important to patients.

Assumptions have changed, sentiments are changing; the Medicare and Medicaid programs must change. As we struggle to reform these two programs in a climate of finite Government resources, we must not overlook the option of finding new revenues to finance health care needed by program beneficiaries. One option that should be considered is the use of cigarette and alcohol taxes to increase the pool of monies available to meet society's commitments to treat patients covered by Government programs. Cost effectiveness is a primary goal, but a balanced program of spending restraint and adequate revenues is necessary to guarantee the future health of all Americans.

References

Brewster, A. C.: A Computerized Clinical Information System for Hospital Quality Control. Westborough, Mass. MediQual Systems, Inc., Nov. 20, 1984a.

Brewster, A. C.: Medical Illness Severity Grouping System (Medisgrps), A Clinically Based Approach to Classifying Hospital Patients at Admission. Westborough, Mass. MediQual Systems, Inc., Nov. 26, 1984b.

Fuchs, V. R.: Though much is taken, Reflections on aging, health, and medical care. *Milbank Memorial Fund Quarterly*. 62(2):143-166, Spring 1984.

Gornick, G., Beebe, J., and Prihoda, R.: Options for change under Medicare: Impact of a cap on catastrophic illness expense. *Health Care Financing Review*. Vol. 5, No. 1. HCFA Pub. No. 03154. Office of Research and Demonstrations, Health Care Financing Administration. Washington. U.S. Government Printing Office, Fall 1983.

Health Care Financing Administration, Office of the Actuary: *1983 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*. June 1983.

Health Care Financing Administration, Office of the Actuary: *1985 Annual Report of the Board to Trustees of the Federal Hospital Insurance Trust Fund*. Mar. 1985.

Lubitz, J., and Deacon, R.: The rise in the incidence of hospitalizations for the aged, 1967 to 1979. *Health Care Financing Review*. Vol. 3, No. 3. HCFA Pub. No. 03141. Office of Research and Demonstrations, Health Care Financing Administration. Washington. U.S. Government Printing Office, Mar. 1982.

National Center for Health Statistics: U.S. Department of Health and Human Services, Public Health Service. *Health, United States, 1984*. DHHS Pub. No. (PHS) 85-1232. Washington. U.S. Government Printing Office, Dec. 1984.

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research: *Securing Access to Health Care, The Ethical Implications of Differences in the Availability of Health Services. Vol. 1, Report*. Washington. U.S. Government Printing Office, Mar. 1983.

Waldo, D. R., and Lazenby, H. C.: Demographic characteristics and health care use and expenditures by the aged in the United States: 1977-1984. *Health Care Financing Review*. Vol. 6, No. 1. HCFA Pub. No. 03176. Office of Research and Demonstrations, Health Care Financing Administration. Washington. U.S. Government Printing Office, Fall 1984.

blank page

Senator Dave Durenberger

Republican Dave Durenberger is serving his second term as Minnesota's senior Senator. As Chairman of the Senate Finance Committee's Health Subcommittee (which oversees the Medicare and Medicaid programs) he has led the drive to improve the Nation's health care system through cost efficiency, competition, and consumer choice, as well as more comprehensive preventive care. He was instrumental in the Medicare prospective payment system, as well as other current and proposed financing reforms. He also chairs the Intergovernmental Relations Subcommittee of the Committee on Governmental Affairs.

Impact on beneficiaries

More than three decades ago, in 1954, the U.S. Congress made subsidization of health care for certain segments of the population a national Government responsibility by broadening the tax exclusions for employer-paid health insurance.

It was within that framework that the Medicare and Medicaid programs were adopted in 1965, to help fill the gaps that employer-paid coverage could not fill for the elderly, the disabled, and the poor.

During the past 20 years, Medicare and Medicaid have removed obstacles to quality health care for millions of elderly, disabled, and low-income Americans. These programs have grown substantially in both the number of beneficiaries that they serve and in the percentage of public and private resources that they absorb.

The size of these programs has been a significant factor in fueling the dynamic growth we have experienced in our Nation's health care system as a whole. And, now, in the 1980's, the Medicare and Medicaid programs have become critical forces in helping to shape needed changes in both the financing and delivery of health care.

By any measure, the beneficiaries of Medicare and Medicaid are better off today than they would have been without these two programs. For millions of Americans, Medicare and Medicaid have meant the difference between living out the final years of life in a caring environment, or in fear and solitude.

Despite these achievements, most beneficiaries realize that Medicare and Medicaid are not perfect. Although many obstacles to obtaining quality health care have been eliminated, important gaps still remain. A substantial financial burden has been lifted from the shoulders of most beneficiaries, but many others are still not adequately covered or are spending an unconscionably large percentage of their income on health care.

Research recently done for the American Association of Retired Persons, for example, indicates that the elderly earning less than $10,000 per year spend an average of 60 percent of their income on medical and health premium costs. The well-to-do, earning in excess of $40,000, spend only 3 percent. Because elderly Americans do not receive catastrophic coverage under Medicare, hundreds of millions of dollars are also being spent each year on unnecessary supplemental "Medigap" coverage.

Also, because Medicare does not structure premiums and benefits to promote disease prevention (that is, "wellness" care), beneficiaries do not have the incentives they need to live longer and more productive lives, altogether avoiding what I would prefer to call our Nation's "sick-care system."

Perhaps the biggest impact, in the recent past, of Medicare on beneficiaries has been the effect of changes in the system that promote choice. The option the elderly now have to buy into a risk-bearing health plan, for example, has the potential for revolutionizing the role that beneficiaries play in selecting the most cost-effective plans with the best reputation for quality.

Under this new relationship with providers, beneficiaries now relate to Medicare much as an employee relates to the employer who provides a choice of health coverage. As this option continues to grow, the Medicare program will oversee and coordinate the plans offered and must offer sufficient choices. However, the provision and purchase of health care will be left to those who know the most about selecting cost-effective and high-quality health care services—competing health plans.

Medicare should and will remain a uniform, federally administered program. The new role and responsibility for beneficiaries as informed and involved consumers will evolve slowly as more areas of the country are served by competing health plans.

Impact on health care providers

The history of health care in America in much of the past two decades has been one of phenomenal growth. As the largest single purchaser of health care, the Federal Government—through its Medicare and Medicaid programs—has been the driving force behind much of the growth that has occurred.

During the past 20 years, Medicare and Medicaid have grown to be 10 percent of the national budget. In 1985, the total health care bill for Americans reached an estimated $450 billion, a more than 80-percent increase in just the past 5 years. That figure represents nearly 11 percent of all the goods and services we produce and consume as a society.

With health care costs reaching these levels, politicians have been getting the message that we are nearing the edge of what people are willing to pay, not just for health care, but for many other things we finance together as a society.

Initially, as the Federal Government looked for ways to address this concern, much of the emphasis was on regulating providers. Facilities regulation, through the certificate of need process and through regional health care planning agencies, was seen as a central feature in controlling the rising cost of health care services.

The Carter Administration also tried to temper rising health care costs through controls on hospital budgets. This approach was flawed in the message it gave to hospitals, that the Government knows better than you do what you should spend and how you should best allocate your resources.

In the late 1970's and early 1980's, however, this emphasis on regulation began to give way to more fundamental health systems reform, through consumer choice and competition. Those of us who have supported this strategy argue that, by changing the economic incentives, doctors and hospitals themselves will determine the best route to a more cost-effective health care system while maintaining quality of care.

In 1982, the Congress passed the Tax Equity and Fiscal Responsibility Act (TEFRA) which sets out a three-point agenda for reform in the Medicare system. Because Medicare is such a large factor in the Nation's health care system, these changes are now being used as a model to alter the financing and delivery of health care for virtually every American.

First on the TEFRA agenda were the limits placed on Medicare payments to hospitals. Medicare no longer makes open-ended payments for whatever costs hospitals formerly claimed were due. The day of the "free lunch" is over. Under open ended, cost-based reimbursements, hospitals had no incentive for constraint. On the contrary, doctors and hospitals had every incentive to apply as many costs per day to a patient's bill as possible. The more charges levied, the more the hospitals would be paid.

Second, TEFRA required the Secretary of the Department of Health and Human Services to report to the Congress on the design for a prospective payment system. In 1983, the Congress incorporated the Secretary's report into the Social Security Act Amendments; these provided that hospital reimbursement be based on the diagnosis assigned to each patient, rather than the sum total for expenses charged that patient each day. This reform, under which patients are now assigned to one of several hundred diagnosis-related groups, has fundamentally changed the way hospital and inpatient care for the elderly is managed. The result so far has been a dramatic decline in admissions and average length of stay. The message is out: "Hospitalize with care and use hospitals frugally."

The third major reform in TEFRA was the provision allowing Medicare beneficiaries a choice of competing health plans that are responsible for providing a wide range of health services to the enrollees. Under this new option, Medicare makes a monthly payment to a health maintenance organization (HMO) or other health plan on the beneficiary's behalf. The beneficiary must, in most cases, also pay an additional monthly premium to the HMO and must agree to receive all medical services through the HMO's physicians, clinics, and hospitals. In exchange, the HMO agrees to provide all the Medicare benefits, handle all paperwork, and pay the Medicare deductible and coinsurance charges.

Although this option has been in effect nationwide for less than 1 year, I am convinced that this type of option provides our best opportunity for ensuring the most cost-effective and appropriate use of health care as determined by providers who are properly rewarded when they succeed.

An important safeguard in the new emphasis on appropriate utilization of hospitals is the peer review organization system under which doctors review each other's admissions and treatments. The peer review process, established under separate legislation passed in 1982, helps ensure that quality care is provided in the hospital and that unnecessary admissions and procedures are not undertaken.

Preadmission screening, which is part of the peer review process, also helps to protect Medicare beneficiaries from having to pay out-of-pocket costs for treatments not covered by Medicare because they could have been provided in a more appropriate setting.

All of these changes are having a dramatic impact on how health care is being delivered. They have an effect on the type of services provided in hospitals, the growth in out-patient services, the new relationships evolving among providers, and the emphasis on prevention and wellness being given by all health care providers.

Throughout much of the history of professional medicine, the emphasis on research, education, new technology, and new facilities has been heavily weighted toward repairing the damage to the human body that occurs after an illness or accident strikes. All of us who are alive today can be thankful for the advances in medical science that have made it possible to cure illnesses and heal injuries that could have resulted in premature death or painful, long-term disability.

However, the greatest challenge now facing health care providers lies in wellness and disease prevention—helping people to avoid altogether the use of the "sick-care system." Many of the changes made during the past several years in the Medicare program are directed at meeting this challenge.

Impact on government

Government's role in authorizing and financing health care programs, or any other programs for that matter, must be partly proactive. Government must be prepared to occasionally change the rules not only in response to change but also to provide incentives for change.

Medicare's traditional split in trust funds, the Part A hospital insurance trust fund and the Part B supplementary medical insurance trust fund, is a good example of a rule of the game that may now need to be redrawn. In the earliest days of Medicare, when the most significant model for health insurance was Blue Cross and Blue Shield, this division in trust funds made sense. Generally, a clear distinction existed between the kinds of services that beneficiaries received in hospitals and those they received in doctor's offices or other nonhospital settings.

But, today, as Part B is being used to pay for outpatient surgery and other procedures as well as traditional doctor office visits, it may be time to reconsider this historic split between Medicare Part A and Part B. The two parts of Medicare are combined for the HMO voucher option. If capitated payments to competitive health plans represents the wave of the future, we may be moving to a defacto combination of the two trust funds, regardless of formal legislative changes.

The relative roles of Medicare and Medicaid in financing long-term care for the elderly may be another major policy question that deserves to be revisited. Viewing the Social Security Act as a whole, for example, one might question whether the income security and health care needs of the elderly might not be better served under a single unit, Medicare. This would allow the transfer of the long-term portion of Medicaid, at least as it affects the elderly, to Medicare.

Currently, almost one-half of Medicaid's expenditures are for outpatient services. This amount, largely for long-term care for the elderly, is growing and rapidly taking funds away from the acute and preventive health care needs of the younger poor, especially young mothers and children. Because of the high cost of traditional long-term care in nursing homes, many older Americans are faced with the inevitability of "spending-down" their resources until they are so impoverished as to qualify for Medicaid. Ironically, many of these individuals would have had resources during their working years to contribute to social insurance for long-term care, if such insurance had been available.

According to a recent survey by the American Association of Retired Persons, 80 percent of the elderly believe that Medicare will cover all their health care needs, both acute and long term. It does not; this leaves many elderly persons with the inevitability of spending themselves poor in order to qualify for Medicaid-financed long-term care. From this perspective, long-term care is as much an income security issue as it is an issue of health care.

Medicaid, in 1985, suffers from a pattern of widely differing and inconsistent funding and benefit levels across the country. For at least 4 years now, we have been practicing a gradual transfer of responsibility for meeting human needs from the Federal to State and local governments. Unfortunately, there has not been a corresponding transfer of resources.

Tax reform, as it has been proposed by the President, may make a bad situation even worse by eliminating the deductability of State and local taxes and tax-exempt bond financing, while increasing the Federal Government's role in levying excise taxes—a field, except in wartime, that has been historically left to the States.

This loss of Federal revenue and increasing pressure on State and local governments to finance programs for the poor is coming at a time when States are facing mounting pressures to lower their own taxes and to grant tax breaks and other incentives to industry for job creation. Even before the most recent scramble for new industry began, the disparity in State commitment to the poor was evident and cause for great concern among individuals who, like myself, believe in a national commitment to our Nation's poor.

Under Aid to Families with Dependent Children, maximum payments to a family of four now vary from $168 a month in Tennessee (the new home of the much-sought-after Saturn auto plant) to $676 per month in New York and $611 a month in Minnesota. Medicaid eligibility and benefit levels follow the same pattern because these two programs are generally linked.

Clearly, Medicaid is not fulfilling its intended purpose of providing a reasonably uniform level of health care subsidies for low-income people throughout the country. Addressing the disparity that exists is one of the major challenges facing policymakers as the Medicaid program prepares to enter its third decade.

Implications for the future

When Medicare and Medicaid were first established, there was also pressure from some quarters to establish national health insurance or even a British-style national health service. But, Medicare and Medicaid were structured to finance health care, not deliver it, indicating the clear intent of Congress not to take over the Nation's largely private health care delivery system. Beyond concerns over cost, a national health insurance system was not adopted largely because it was not needed. The private sector, with tax subsidized, employer-paid health insurance, now provides nearly universal coverage when linked with Medicare and Medicaid.

Before one becomes too complacent about the extent of coverage, however, it is important to recognize that no fewer than 20 million Americans are currently underinsured, having been left out of the Government's complex safety net of tax subsidies, social insurance, and direct Government support. These individuals include those just above the income limits for Medicaid, many of the self-employed and unemployed, spouses who are no longer covered under a group plan because of a recent death or divorce, and individuals who work for employers who do not provide group coverage but who cannot afford the horrendous cost of buying health insurance protection on their own.

The health care these individuals receive is spotty and often available only when the cost of treatment becomes very expensive. In the past, the uninsured have largely depended on public hospitals or the good graces of private institutions. However, both public and private hospitals are much less able to subsidize care for the indigent in today's competitive, cost-conscious environment. There is also little room for prevention and wellness care under these kinds of circumstances because health care is generally not sought out until an accident or serious illness occurs.

Filling these gaps in coverage is one of the major challenges now facing Federal health policymakers. The Federal Government must recognize its responsibility to provide targeted and adequate subsidies to get all Americans into health plans, and, thus, into the health care system, while at the same time not wasting scarce resources on excessive levels of coverage. At a minimum, Federal tax law should recognize the current inequity of providing an unlimited tax subsidy for health insurance to individuals who are in employer-financed group plans, but no tax subsidy to those who are not. If we were to cap the tax subsidy for employer-paid health premiums, then we could use the savings to provide a tax deduction for those without employer-provided group coverage, such as the self-employed and the unemployed. For those who continue to fall between the cracks, States and local governments may have to provide additional services and funding. But the Federal Government must provide its share of financial support as well, so that all Americans will have fair access to the Nation's health care system.

The greatest failing of the current Medicare system is its absence of coverage for catastrophic illness. One can see this weakness in the hundreds of millions of dollars that the elderly spend each year on expensive and often unnecessary supplemental or catastrophic coverage.

In an era of $200-billion-per-year deficits, however, there will be considerable pressure to make the addition of catastrophic coverage to Medicare revenue neutral. The answer to this seeming dilemma may be to recognize that current cost-sharing in Medicare is not sensitive enough to the range of incomes available to Medicare beneficiaries. Many of the well-to-do elderly, in other words, could afford to pay more.

It is unconscionable that the elderly earning less than $10,000 a year spend 60 percent of their incomes on medical and health premium costs while those with incomes in excess of $40,000 spend only 3 percent, particularly when Medicare continues to ignore the kind of catastrophic illness expenses that most older Americans fear most. To address these concerns, I have proposed that we use a modest extension of cost sharing at the high end of the income scale to finance a catastrophic insurance program under Medicare for all beneficiaries. Such a change could be made budget neutral, could save hundreds of millions of dollars a year in supplemental coverage, and would satisfy one of the Medicare program's greatest failings.

Beyond efforts to fill gaps in coverage for beneficiaries, I would expect that much of the attention of the Congress will continue to be directed toward expanding the twin principles of prospective payment and capitation. I expect that the Congress will labor long and hard, for example, over how to extend prospective payment concepts to physicians, skilled nursing facilities, home health care providers, and hospices. This time will not be badly spent, but I am hopeful that eventually the decision on how health care providers are reimbursed will not rest with the Congress or the Medicare system, but with competing health plans.

The shift toward prospective payment and capitation will also require that attention be given to parts of the health system that were formerly subsidized within fee-for-service reimbursement. Graduate medical education, care for the indigent, research, and new technology development are also needed services that have, heretofore, been financed indirectly, but which, in the future, may need to be financed directly and explicitly.

As for Medicaid, the States are currently awash with reforms, many of them aimed at holding down costs in response to Federal cutbacks and increased pressure to lower taxes as a way of attracting new jobs and industry. Capitation through Medicaid voucher programs is being tried in a number of States, along with strong efforts to utilize more cost-effective settings for the delivery of health care services to the poor.

With these changes, access may become a real problem for many Medicaid beneficiaries. The purpose of Medicaid was, traditionally, to avoid the continuation of a two-tiered system of health care delivery, one for the rich and one for the poor. Unfortunately, Medicaid has not fulfilled its promise in meeting this goal.

As more Medicaid beneficiaries are encouraged to seek the services of competing health plans, this problem may be alleviated. Capitation of health care for the poor carries with it the potential for abuse, the "Medicaid milk" of the early 1970's being indelibly etched on the minds of policymakers. The potential for abuse should not stop us, however, from making choices of competing health plans a goal of the Medicaid program as it has become a goal of Medicare.

As we continue to adapt Medicare and Medicaid to the changing health care environment of the 1980's, both programs will need benefit restructuring that takes into account disease prevention and health promotion as well as protection against acute illness. Medicare, in particular, was designed on the model of Blue Cross and Blue Shield, an insurance program largely for the employed population. Medicare was developed at a time when the importance of lifestyles in health was much less understood.

Today, however, we know more about the hazards of smoking and other abuses and the potential of prevention. Changing lifestyles can alter the risk of illness for the elderly just as much as for any other age group in the population. It is time that Medicare recognized this reality.

The same is true for low-income people. In many States, for example, relatively inexpensive prenatal care is not funded under Medicaid. Yet, we know that low birth weight is one of the primary causes of early childhood illnesses, as well as long-term health problems such as mental retardation, cerebral palsy, epilepsy, and learning disabilities. By spending just a little extra money at the front-end of life, studies have shown that big-dollar savings and generations of healthier babies can result from a greater emphasis on the most cost-effective incubator of all, the mother's womb.

Finally, any examination of the future of the Federal Government's role in financing health care cannot ignore the issue I raised earlier about long-term care.

On the one hand, I believe it is not appropriate to continually drain the resources of Medicaid to finance the long-term care needs of the frail elderly and disabled. However, there is something drastically wrong with a system under which millions of elderly Americans must spend themselves into poverty to qualify for a Medicaid program that will finance increasingly expensive long-term care.

Although the appropriate directions for health system reform in long-term care are not as clear cut as they are on the acute side, I am convinced that the principles of consumer choice and competition are relevant and need to be further explored.

Rethinking the relationship of long-term care to income security as well as health care may result in linking social insurance benefits provided under Social Security, acute care financed under Medicare, and long-term care financed under Medicaid. We may also need a new financing mechanism that allows individuals to purchase long-term care insurance while they are still working.

These challenges of filling in gaps of coverage, encouraging the use of the most cost-effective quality care available, encouraging an increased emphasis on health prevention and wellness, and continuing the evolution toward increased competition and consumer choice, are all at the top of the health care policy agenda as Medicare and Medicaid prepare to enter their third decade.

These are not easy challenges to meet, but I am confident that we will address them with the same spirit of caring and high quality that has driven these two programs in their first 20 years of service to the American people.

blank page

Karen M. Ignagni

Karen M. Ignagni handles health care policy issues for the AFL-CIO. She is a member of the Board of Directors of the American Health Planning Association and the Washington, D.C., Health Care Coalition. Her previous experience includes serving as a professional staff member for the U.S. Senate Labor and Human Resources Committee, Assistant Director for the Committee for National Health Insurance, and as a health care research analyst for the Department of Health, Education, and Welfare. She received a Master of Business Administration degree from Loyola College.

Impact on beneficiaries

Like a proud relative offering a toast to the birth of a child, President Lyndon B. Johnson articulated the hopes and aspirations of all Americans when, at the signing of the Medicare Act, he declared:

> "No longer will older Americans be denied the healing miracles of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years."

The goal of Medicaid was equally far-reaching. The poor were promised that within a few short years after enactment of the legislation they would have access to the medical mainstream. Unfortunately, because of a series of political compromises made to secure passage of both Medicare and Medicaid, not all of these promises have been kept.

To deflect opposition from physicians, Congress agreed not to attempt to control the future cost of the Medicare program by limiting provider reimbursement. However, Congress was willing to use the goal of cost containment as the justification for restricting the scope of Medicare benefits. In Medicaid, for the alleged goal of "administrative simplicity," Congress tied eligibility for benefits to preexisting State welfare categories. As a way of avoiding opposition to the Medicaid legislation from advocates of States' rights, Congress conceded control over the development and administration of the program to the States. This action was justified by then Secretary of Health, Education, and Welfare, John Gardner, who described the Medicaid legislation as an example of "creative federalism."

To be sure, Medicare has had impressive results. Since its passage, overall access to care has improved, especially for poor beneficiaries, and mortality rates for the aged have sharply declined. For the disabled and victims of end-stage renal disease, Medicare has filled a major gap created by the unwillingness of private insurers to design an insurance product that could affordably and effectively meet their health care needs. With Medicare expenditures consuming a growing share of the entire Federal budget, voices that call for placing limits on the program and forcing the elderly to pay a larger share of program costs have grown stronger. At this writing, Congress appears on the verge of authorizing cutbacks that could jeopardize some of the improvements in health brought about since the beginning of the program. Those who hope to reduce Medicare costs by merely shifting a greater financial burden to senior citizens will only move us further away from President Johnson's 20-year-old goal of providing health security to beneficiaries.

At present, Medicare offers inadequate protection against the high cost of health care and the prospect of financial ruin associated with a serious illness. Senior citizens now are paying out of pocket the same percent of income that they did prior to the enactment of the program. Currently, that amount averages approximately $1,700 per individual. For catastrophically ill beneficiaries, the out-of-pocket burden is much higher, because the Medicare benefit package was modeled after the basic insurance package of the early 1960's. It was designed to cover acute care at a time when chronic conditions could not be managed as effectively on an outpatient basis as they are today, and when patients did not live as long as they now do. Consequently, Medicare has limited the number of covered days per spell of illness and requires steep beneficiary copayments after the 60th day of hospital care.

The emphasis on inpatient care is further reflected in the refusal of the program to pay more than 80 percent of the cost of outpatient physician services up to a certain level. However, because physicians are not compelled to limit their overall charges to what the Government is willing to reimburse, the 20-percent cost of physicians' fees that beneficiaries are required to cover actually ends up being much higher. In 1984, for example, Medicare paid less than 60 percent of the elderly's cost for outpatient physicians services. This situation will only get worse as the configuration of the health care delivery system changes and more emphasis is placed on outpatient physician services, where there are no limits on what physicians can charge, only what Medicare will reimburse.

In addition to cost-sharing requirements, many benefits (including routine physicals, dental care, and outpatient prescription drugs) that would significantly improve the health status of the entire Medicare population remain uncovered. Special mention should be made of the complete lack of protection under Medicare for long-term care. Because Medicare has refused to accept its fair share of the burden for chronic care, the responsibility has fallen on State Medicaid systems, where the aged are required to pauperize themselves and, in some cases, sign away their homes before becoming eligible for benefits.

Senior citizens in need of long-term care should not be forced to make such draconian choices.

The Medicaid legislation gave a State the option "as far as practicable under the conditions in such State" to provide medical assistance to categorically eligible individuals "whose incomes and resources are insufficient to meet the costs of necessary medical services." In effect, the crucial decisions concerning Medicaid were not what was put into the legislation, but what was left out. Medicaid was never designed to provide medical assistance to all of the poor and, as a result, today less than 50 percent of the population living below the poverty line are eligible for services. States were not required to participate in the program. Nor did the legislation provide specific guidelines on coverage (i.e., number of visits) that were to be provided for each benefit category. Because of this, considerable variation in coverage exists among States.

Unlike Medicare, Medicaid does not cover all of its beneficiaries on the same basis. There are no national income guidelines for qualification, and the system for determining Federal Medicaid matching payments has substantially contributed to inequities among States in the percent of the poor covered by the program.

The present system of basing Federal matching payments to States on the average of per capita income for the 3 years prior to the current year, means that payments are based on income data going back 4 years. This time lag makes Medicaid an inappropriate countercyclical tool. In addition, basing the formula on average per capita incomes disproportionately penalizes States with a relatively high concentration of people below the poverty line. In effect, if States A and B receive approximately the same Federal match but B has more people living below the poverty line and eligible for benefits, B will have to put in more of its own resources or cut back on benefits. Although the issue of the Medicaid match is quite controversial, it must be addressed. Per capita income should not be the primary determinant for assistance. A more equitable balance could be struck in the distribution of matching payments across States if income per person in poverty were used instead of per capita income.

Even once individuals are deemed eligible for Medicaid they have far from unlimited access to providers. Research has indicated that only 6 percent of all physicians care for one-third of the beneficiary population. Delays in payment, burdensome paperwork requirements, or an overall unwillingness on the part of physicians to treat Medicaid patients are some of the reasons cited to explain this unacceptably low ratio. Like Medicare, Medicaid encourages the utilization of inpatient care, which accounts for 70 percent of the program's expenditures.

To some extent, Medicaid's unreasonably low payments to providers who perform services on an outpatient basis contributes to the high utilization of inpatient care. A major problem, however, is that Medicaid has become the last resort for senior citizens who have lost their savings because of catastrophic medical expenses not covered by Medicare, for the medically retarded, and for the developmentally disabled in need of chronic care. Medicare's benefit limitations force the elderly to give up everything, including their pride, to be deemed eligible for Medicaid benefits. Similarly, the disabled have no other source to turn to for assistance in meeting high costs associated with chronic care.

The major challenges ahead for Medicaid include improving services to a broader cross section of the poor. Unless Medicare is prepared to assume the long-term care burden for its beneficiaries, States may be financially unable to meet this objective.

Since 1981, cutbacks (as a result of reductions in Federal matching payments and rising program costs) have made almost one million poor women and children ineligible for the program and have narrowed the scope of benefits to which others are entitled. These changes have negatively affected the health of certain beneficiaries and, in some States, have contributed to a dramatic reversal in the progress which had been made in reducing infant mortality.

Impact on health care providers

The original Medicare bill did virtually nothing to control provider behavior for fear that the entire legislation would be killed by physicians who opposed it. In 20 years, the Nation has paid dearly for that decision. The reticence to create a public insurance system where the relationship between payer and insurer differed in any respect from the insurance model prevalent at the time only institutionalized the problems inherent in that system and paved the way for a potential solvency crisis in the Medicare Part A trust fund.

Several years ago, when it was thought that Medicare's hospital insurance trust fund would go bankrupt, public policymakers desperately sought solutions to ward off a potential crisis. This collective concern about the political fallout that would occur were Medicare to become insolvent led to a major revision in the method of paying hospitals participating in Medicare. The Federal Government tore up the blank checks it had been giving to providers since the start of the program and began reimbursing hospitals on a prospective basis, by letting them know ahead of time how much they would receive for each diagnosis.

Although organized labor has long advocated prospective reimbursement, we have reservations about this particular approach. Not only should it be closely monitored to gauge its impact on access to and quality of health care for beneficiaries, the prospective payment system (PPS) should be modified to address the following concerns. Preliminary evidence indicates that hospitals may be releasing beneficiaries before they are ready to be discharged; readmitting patients with the same diagnosis; improperly classifying patients; and unbundling services to shift the source of payment from Part A to the unregulated Part B. These changes should be investigated and appropriate actions taken.

The Department of Health and Human Services must make adjustments in payments for hospitals that serve a disproportionate number of low-income people, and Congress must address the inequity of expecting providers to treat more complex cases without adjusting the payment rate. Absent these changes, the current system makes certain patients undesirable to treat, will continue to be a barrier for these patients, and will drive public and inner-city hospitals further into the red.

Confining PPS to operating costs has encouraged hospitals to substitute capital for labor. This is potentially detrimental to both quality of care and low-waged hospital workers who, as a result of PPS, are being shifted from full-time to part-time status or laid off altogether. Return on equity allowances, which gives an unfair advantage to for-profit facilities, should be eliminated. Limiting PPS to Medicare has created an incentive for hospitals to shift to the private sector costs in excess of the amounts reimbursed by Medicare. Finally, a cost-containment program that excludes physicians, who play such an essential role in the system, does not offer a permanent solution for reform. From the standpoint of the beneficiaries, it would be far better to increase physicians' payments in accordance with an exogenous price indicator, rather than freezing the level of payments and encouraging more physicians to refuse to accept assignment.

In addition to modifying PPS, other changes could be implemented to improve the program's infrastructure. Medicare has encouraged physicians to perform as many procedures as possible on an inpatient basis. Indeed, hospitalization has become the Medicare norm. Although the trends in hospital utilization and length of stay for all patients, including Medicare, continue to drop, now is the time for Congress to consider implementing changes to assure that providers participating in Medicare practice in an efficient and effective manner. At the same time as changes are being made in the system that result in shorter, more intensive hospital stays, it is totally inequitable to continue to peg beneficiaries' hospital deductible to the cost per hospital day.

The international unions affiliated with the American Federation of Labor and the Congress of Industrial Organizations (AFL-CIO) have been effective in joining with their management counterparts around the country to implement initiatives to reduce the costs of collectively bargained health benefits and improve quality of care. In our view, many of these cost-containment initiatives could and should be incorporated into Medicare's benefit structure. The following changes could be considered:

- Instituting a prior authorization program for hospital stays and mandatory second surgical opinion requirements.
- Developing a program to prospectively assign length of stay for inpatient services. Rebasing the current payment system, which rewards physicians for unnecessary testing and penalizes them (in a relative sense) for spending time with patients to diagnose their problems.
- Reimbursing at a higher rate certain surgical procedures that can be safely done on an outpatient basis.
- Authorizing the development of a broad range of alternative delivery systems to be offered to beneficiaries, including preferred provider organizations (PPO's) in addition to health maintenance organizations which beneficiaries are now entitled to join.

To implement these proposals, the Department of Health and Human Services would have to broaden the scope of administrative responsibilities assigned to Medicare intermediaries, and establish a competitive bidding process. In the case of PPO's, one option might include allowing States, in addition to Blue Cross and private health insurers, to function as brokers and negotiate new purchasing arrangements with providers. Intermediaries should be directed, to the extent practicable, to give priority to negotiating capitation arrangements with providers.

No discussion of the impact of Medicare on providers would be complete without discussing the issue of long-term care. Because Medicare has not provided coverage in this area, it has taken no action to attempt to influence or even encourage the development of a long-term care delivery system. Medicare's limited attempt to provide narrow coverage for skilled nursing home care has been fraught with administrative problems. Program intermediaries are virtually left to their own devices in administering this service, and there currently exists a patchwork system of varying effectiveness from State to State.

The realization that Medicaid costs would have to be controlled was the excuse given early on by States to prevent broadening of coverage. Ironically, Medicaid amendments that were designed to limit reimbursement to providers were largely ineffective and, throughout the 1970's, costs rose at double-digit rates. As Medicaid began to crowd out spending for other services, States sought to contain costs by instituting changes in the Medicaid delivery system that limited beneficiaries' freedom of choice of provider. In 1981, the Omnibus Budget Reconciliation Act gave States this desired flexibility.

Initiatives launched under this legislation have included case-management programs, alternative delivery systems, and selective contracting. Some have expressed fear that these changes will only reduce quality and restrict access for the poor. However, given the low provider participation rate for Medicaid, few beneficiaries have ever had real freedom of choice. Indeed, early experience with selective contracting placed a disproportionate emphasis on price and did not give equal weight considerations of quality or access. However, there are growing indications that these issues can and must be addressed.

It is crucial that State Medicaid agencies closely monitor the qualification of participating providers, investigate whether providers are attempting to keep costs down by unfairly restricting access, and explore grievances. Conceivably, well-run case-management systems and selective contracting programs could improve Medicaid's provider participation rate and give beneficiaries broader entry into the health care system.

Impact on government

Whether the health care needs of Medicare beneficiaries can be affordably and adequately met through the current system is an issue that will be debated for years to come. One proposal that has been advanced is the notion of moving Medicare to a voucher system; beneficiaries would receive a chit equivalent to the dollar value they are entitled to and told to go out into the market and "shop" for the health insurance plan that comes closest to meeting their needs. Experience in private sector benefit plans suggests that the largest, most powerful purchasers are able to negotiate the most favorable terms in the health care market. Sending beneficiaries into the system to negotiate individual arrangements would allow insurers to pick and choose among the best risks. As a result, it could leave many seriously ill beneficiaries inadequately protected and the Government extremely vulnerable, having lost the economic advantages inherent in pooling risks and the ability to use its market share to positively influence provider behavior.

Rather than moving in the opposite direction, Medicare, through its intermediaries, should use its market position to negotiate with providers on behalf of beneficiaries. It should also require that, as a condition of doing business with Medicare, physicians should accept assignment and hospitals should be prohibited from refusing to treat certain patients and dumping them onto other facilities.

Another proposal for reducing the costs borne by the Federal Government for providing health insurance to senior citizens would involve creating individual retirement accounts (IRA's) for medical care. Even if a tax credit were proposed to circumvent the criticism that IRA's only benefit those with relatively high disposable income, public policymakers must consider the opportunity costs associated with medical care expense accounts. Private insurers have testified that they cannot duplicate the Medicare benefit package at an affordable cost, because of the minimization of adverse selection and the benefit of combining good and bad risks. How then could individuals afford the cost of health care services? Several hospital stays could quickly drain individuals' resources, which would force the Federal Government to develop an expensive residual program to allow individuals to continue to receive medical care once they exhausted their savings.

Another variant of the philosophy that Medicare eligibility should be contingent on financial need is the proposal to scrap the Medicare social insurance system in favor of a means-tested program. Individuals who have contributed to the social security system should be eligible to receive Medicare as a matter of right so, as President Johnson promised, they might "enjoy dignity in their later years." Moving to a means-tested program only would create similar inequities and coverage gaps that are prevalent in the Medicaid program, which has caused a growing percent of the population to fall through the gaping holes of the so-called "safety net."

The major strengths of the Medicare program are its uniform eligibility and benefit standards. From a cost perspective, a major weakness has been the system of basing physicians' payments on the usual, customary, and reasonable charges of their colleagues. Another major weakness in Medicare is the discretionary nature of assignment, as well as the fact that there is minimum accountability in the system given the geographical remoteness of the Federal Government from local health care providers. The most effective way to circumvent this problem is to empower intermediaries to negotiate with areawide providers on Medicare's behalf.

A final point concerning weaknesses involves the issue of the inclusion of Medicare in the consolidated Federal budget, which results (as it did this year) in arbitrary decisions being made concerning the programs that are not based on the conditions in the trust fund.

Experience in recent years has demonstrated that there are some advantages to States administering Medicaid. The proximity of States to local health care providers puts them in a better position to develop managed health care systems and a range of alternatives to meet the acute as well as chronic health care needs of beneficiaries. The major disadvantage associated with the present system is that States are administering 50 different Medicaid programs with varying eligibility standards and benefit levels, and these are inextricably linked to the overall economic position of each State.

Congress should step in and develop national criteria for Medicaid eligibility and level of benefits. There also is a need for Congress to provide the financial support that would allow Medicaid to begin to address the health care needs of a broader population of economically disadvantaged citizens, including jobless workers and their families. Congress also should explore alternatives for providing countercyclical assistance to States to enable them to maintain their level of Medicaid benefits during periods of recession.

Another issue that Government cannot afford to ignore is the link between the supply of nursing home beds and State efforts to contain the growth in Medicaid expenditures. The percent of the population in need of nursing home care has grown considerably since 1965. However, Medicaid is the lone third-party payer for long-term care. Fifty cents out of every dollar going to nursing homes comes from Medicaid, and long-term care consumes 50 percent of the Medicaid dollar.

Concern about the growing burden of long-term care has caused States to use their market clout to restrain nursing home capacity for fear that as the supply of beds expands, so will Medicaid expenditures. In effect, States are holding hostage the population in need of long term care.

Yet, it is difficult to urge States to change their behavior, given the unresponsiveness of the Federal Government and the private sector. Congress has showed no interest in the long-term care needs of Medicare beneficiaries. It has left it to the States to fill in the gaps in Medicare coverage. Based on the data compiled by the Health Care Financing Administration, States have met this challenge, but it has been at the expense of other State programs, other Medicaid beneficiaries, and the elderly themselves who have been forced to turn over their hard-earned savings and, in some cases, their homes in exchange for Medicaid protection. Similarly, the private sector only recently has become more interested in helping to fill this void. It remains to be seen just how affordable and effective potential private insurance products will be in this area. Until Medicare bears a fairer share of the long-term care burden, the States will continue to restrict nursing home capacity and a growing number of citizens could be denied care.

States face another Catch-22 as they attempt to develop home and community-based care. Not only have the States been required to pioneer an entirely new delivery system, but they also have been required to develop procedures for licensing an entirely new group of health care providers. States fear that if these new initiatives result in higher Medicaid costs, the Federal Government will rescind their waivers and reduce matching payments.

Implications for the future

With 20 years of experience with Medicare and Medicaid behind us, we must look back at the compromises that were made to secure congressional passage of these programs. We must ask whether we can afford to let the political situation that prevailed two decades ago continue to stand in the way of comprehensive reform.

Even though both Medicare and Medicaid have significantly improved access to care, they still fall far short of meeting the objectives outlined by President Johnson. In Medicare, a number of essential services remain uncovered and, relatively speaking, the elderly are bearing the same share of the financial burden for health care services as they were prior to enactment of the program. As for Medicaid, 20 years of hindsight have demonstrated the extent of the problems that can occur when the Federal Government shifts its share of the responsibility for implementing social programs to the States. Examples of such problems include the recent wave of cutbacks in Medicaid benefits and restrictions in eligibility as a response to reductions in Federal payments to States and rising program costs.

The results of national polls have demonstrated public support for comprehensive reform of the health care delivery system. Given the interdependent relationship between the public and private health care programs, we cannot effectively improve access, assure quality, and contain costs in Medicare and Medicaid without systemwide reform.

blank page

Barbara D. Matula

Barbara D. Matula is Director of the Division of Medical Assistance, and is responsible for administering the Medicaid program for North Carolina. She has chaired the State Medicaid Directors Association since 1982. She is a delegate to the National Council on Aging's section for home- and community-based care, and is involved in the Brookings Institution and Stanford Research Institute's studies on alternative financing for long-term care, as well as State and national studies of indigent care problems. She received a Bachelor of Arts degree from Rider College in Trenton, N.J., and a Master of Public Administration degree from the State University of New York at Albany.

Impact on beneficiaries

One of the most important contributions of the Medicare program is that it legitimized the role of the Federal Government in assuring that the basic health care needs of the elderly would be met, regardless of their income or health status. To the elderly, the establishment of Medicare eased their fears that they would be denied or could not afford insurance coverage for expensive health care services when they were most vulnerable and in need.

Government, as the insurer, promised that the Medicare program would be universal in its eligibility requirements, uniform in its benefit package, affordable, simple, fair, and acceptable (i.e., there would be no stigma attached). Because Medicare was modeled after typical private health insurance plans, it encompassed their shortcomings as well as their strengths.

Private plans traditionally emphasized hospital or acute care and were intended for younger healthy workers and their families. Thus, the package of services available for Medicare beneficiaries does not address either their most prevalent primary care needs for eyeglasses, hearing aids, dentures, prescription drugs, etc., or the catastrophic costs of long-term institutional care, which they are at risk of needing.

In addition to out-of-pocket costs for uncovered services, beneficiaries must pay monthly premiums, deductibles, coinsurance and, if the physician does not accept Medicare payment, any charges levied on them by nonparticipating providers. In effect, this means that the financial liability of Medicare beneficiaries is virtually unlimited.

To protect themselves, beneficiaries are apt to purchase any number of supplemental insurance policies, only to find that coverage for expensive long-term care is tied to restrictive Medicare policies and, therefore, of extremely limited value in the event of catastrophic illness.

To its credit, Medicare has been in the forefront promoting home health and hospice benefits, which are seen to be less costly and in many ways more humane than institutional care. But, in another way, Medicare has caused serious concern among beneficiaries because of the decision to move to diagnosis-related groups (DRG's) without assuring adequate alternate support systems. The fear that hospitals will prematurely discharge patients too ill to be released is a real concern among the elderly. Medicare's restrictive nursing home coverage policy lends credence to the notion that "dumping" will take place at the beneficiaries' expense.

Other program goals have evolved that do not relate to existing policies. For example, a recent proposal would have increased beneficiaries' liability for hospital stays in an effort to decrease lengths of stay and avoid unnecessary admissions. This proposal completely ignores the intense emphasis given to pre- and post-admission reviews and the effect of DRG's on lengths of stay; in addition, it gives the appearance of arbitrarily shifting costs to beneficiaries.

There are several fundamental issues that soon must be faced by beneficiaries and policymakers, but first there must be a clearer understanding by the public of the current program limitations, the anticipated demand for services in the future, and the cost of providing these services. Heightened public awareness is critical to the direction Medicare takes.

As Americans live longer, they must be better prepared financially to meet their changing needs over a longer period of time than previously anticipated. Long-term care insurance is one example of assuming this personal fiscal responsibility.

The elderly should have more choices in the kinds of services that are available to them and the amounts to be paid for these services. This "cafeteria" approach would include capitated or prepaid arrangements. They also should be given more information and choices concerning provider fees and participation.

The existence of Medicaid has made health care available to millions who would have had to depend on charity care or on limited local programs to meet their basic needs. Prior to the inception of Medicaid, benefits differed not only among States, but within States.

Medicaid mandated a minimum package of health care services and allowed a wide range of optional services to be offered. Those who meet eligibility standards set by individual States are assured that they will receive medically necessary care, regardless of where they live within the State. There may be minimal copayments for certain services, but providers are not allowed to bill Medicaid recipients in excess of the Medicaid payment.

Children receive the most extensive package of services under the early, periodic screening, diagnosis, and treatment program (EPSDT), and recent expansions of services to children and to poor pregnant women have been hailed as the most positive steps the program has taken since it began.

The elderly and disabled poor, however, benefit the most from the Medicaid program. If they meet the rather stringent Medicaid eligibility requirements, they are entitled to receive a wide range of services not covered by Medicare, especially long-term institutional care. In addition, Medicaid pays their monthly premiums, coinsurance, and deductibles. Health care providers cannot charge these "dual eligibles" above the Medicare/Medicaid payment rates.

For the disabled, Medicaid is especially valuable in several ways. First, Medicare does not cover the disabled for the first 2 years of their disability, and Medicaid is available to fill the gap for those who qualify. Second, for the seriously disabled requiring institutional care, Medicaid offers unlimited coverage at virtually no cost to the patient or his or her spouse, or, in the case of an institutionalized child, at no cost to the parents.

Although some minor problems exist for Medicaid beneficiaries, the real problems exist for nonrecipients, those who cannot qualify because of differences among and within States.

These differences mean that people of similar economic circumstances may not qualify for or receive help depending on where they live. Equal access is denied geographically because of different income eligibility levels, different categories of eligibility covered, different services offered, different limitations and restrictions on services, and different copay amounts among the States. Even within a State, poor people of equally low income may not qualify because they do not receive public assistance or because they are living at home rather than in an institution. On the other end of the scale, the treatment of family income, "deeming," may mean that the institutionalized spouse or child may be Medicaid eligible regardless of how high the family income is. A family's income is considered to be available to the adult or child living at home; it is not counted if the adult or child is institutionalized.

In States that do cover the "medically needy," people whose income is above the public assistance level but below or near poverty may be required to spend 50 percent or more of their incomes on health care before Medicaid will cover them. Under normal circumstances, 15 percent of income spent on health care is considered to be "catastrophic," yet for these very poorest of the poor, there is no such reasonable limit on the liability they must incur before becoming Medicaid eligible. Medically needy income levels are tied to States' payment levels for Aid to Families with Dependent Children, which in many cases have not kept pace with inflation. Another of Medicaid's shortcomings, most of which are eligibility issues, is the "categorical" nature of the eligibility requirements. It is not enough to be poor; you must fit a "category" of eligibility covered by that State to be eligible, such as over 65 years of age, pregnant, in foster care, etc. A single adult male or childless couple who does not qualify as blind or disabled cannot qualify for Medicaid in any State, no matter how poor they are or how great their medical needs are.

For the beneficiaries then, Medicaid eligibility requirements are, for the most part, too stringent, too complex, too limited in length of time covered, and biased toward institutional care.

The most positive developments in recent years have been the expanded coverage of pregnant women and poor children, regardless of family composition, and the enactment of legislation authorizing home-based and community-based services, innovative payment and delivery systems, and preventive care services for adults similar to those available for children. Each of these measures has great promise of delivering needed services at a lower cost today and, more important, offers long-range benefits to the recipient as well as to the program.

One of the major challenges to the beneficiaries and to the policymakers in the future is to prevent the "institutionalization" of Medicaid and, instead, to make Medicaid services available to more of the Nation's neediest people who are arbitrarily denied eligibility.

To prevent long-term care institutional costs from consuming an even greater share of the Medicaid budget, other sources of funding must be identified for the elderly, disabled, and mentally retarded, and less expensive alternative living arrangements must be developed. This suggests the need for Medicare restructuring, long-term care insurance, increased family responsibility, elimination of abuses wherein wealthy beneficiaries can divest themselves of substantial assets in order to become Medicaid eligible, and innovative private financing arrangements for social support, residential, and health care needs of middle- and upper-income elderly and disabled beneficiaries.

Impact on health care providers

In an effort to dispel the notion that the United States was embarking on a course that would result in "socialized medicine," Congress enacted, and the Administration carried out, a Medicare program that basically mirrored the private health insurance industry, with a segment of that industry employed to run the program. Given the extraordinary benefit of hindsight, it would appear that too many concessions were made to health care providers if not to gain their support, then to diffuse their opposition. Recent developments in reimbursement systems, for example, would suggest that public officials today are taking a harder line and compromising less with these powerful interest groups, in order to gain control of inflationary increases.

The initial key decisions that affected providers most favorably were cost-based reimbursement principles and nonmandatory assignment. An even more favorable decision affecting providers was universal eligibility, in that it relieved them of

best copy available

burdensome eligibility verifications. What services were covered and what limitations, if any, were placed on them, was important to the providers of those services; for example, the entire nursing home industry was built on Medicaid coverage.

Other key developments in both programs were the primary role of the physician, the emphasis on hospital care, the initial lack of effective utilization controls, and the use of familiar insurance organizations as fiscal intermediaries between Government and the providers.

When compared with Medicare, Medicaid appears to be an afterthought. In some ways, it mimicked Medicare policies, especially in reimbursement methodologies. In other areas, it took a markedly different approach, especially in mandatory assignment for providers. Before Medicaid, providers treated the poor as charity patients, or they received some small reimbursement from governmental, religious, or civic organizations for their efforts. This created a climate quite different from Medicare in which early Medicaid policy decisions were made.

In general, stricter utilization controls were mandated, fraud and abuse detection was emphasized, State options on reimbursement usually meant lower rather than higher reimbursement rates, and the program was more complex so providers usually dealt directly with governmental administrators.

Because States administer the program, the arrangements for claims processing and utilization review are many and varied. How providers view this diverse and decentralized administration depends on their relationship with their State, and this may range from hostile to amicable.

As mentioned earlier, the nursing home industry was launched because of the Medicaid program. In addition, other health care providers such as dentists and pharmacists, who traditionally had not been included in private insurance plans or in most charitable arrangements, were now, for the first time, able to receive payment for services to the poor if the State elected to cover them.

With Medicaid payments came a great deal of oversight and audit, something that was initially strongly resisted.

The future seems to call for more managed-care concepts—the physician or the health maintenance organization as case manager—in an effort to stem abuses arising from fee-for-service and self-referral arrangements. Providers may not have the luxury of independent practice and specialization that they have enjoyed in the past. For Medicaid patients, more effort must also be put into nutritional counseling, early prenatal care, child development counseling, geriatric education and counseling, etc. More inter-disciplinary team work will be needed to offer the services needed by this segment of the population, if their overall health status is to improve.

Impact on government

The key decision to reimburse providers based on cost and intensity fueled the inflationary fires that recently threatened the Medicare program's solvency. As this is brought under control, attention must be given to the inevitable problem of the Government financing a program, with a shrinking labor force, relative to an ever-increasing number of eligibles. Because the demographics are not favorable, the initial inclination is to reduce program benefits.

Any effort to adjust the financing arrangements is going to be met with resistance if beneficiaries see it only as a reduction of benefits and a shifting of costs. You cannot redraw the contract until you have assured the public, both the payers and the beneficiaries, that you have wrung out all the excesses and possible abuses in the current contract. Nor can you take the same package of services, which is now considered inadequate to meet the elderly's needs, and simply charge more for it. It would be difficult, if not impossible, to sell the notion of paying more when so little is actually covered.

At the same time, not only have the numbers of Medicare beneficiaries grown, they are living longer and are more at risk of needing more care as they reach 75 years of age or over. In the earliest planning stages for Medicare, it is unlikely that this phenomenon was predictable. Now it is essential that middle-aged workers anticipate and plan for their lengthened retirement years, and that they approach public policy decisions on health care for the elderly with this in mind.

Possible solutions might include a choice of benefit packages with varying charges for each. New delivery systems and cost-effective alternative care may bring down the unit cost of caring for the elderly and disabled, but it would be unfortunate if we were to delude the public by claiming that we can meet even the most basic needs of a fast-growing number of people without increasing the revenue base. Sources for increased revenues may include taxes, private insurance or investments, such as individual retirement accounts, home equity, liquidation of assets intended for succeeding generations, increased charitable contributions, or increased family responsibility.

How does society decide on the appropriate share of the gross national product to devote to health care? It does not, at least not consciously. The public does not have the opportunity to vote for a budget as such and allocate the funds as it sees fit. Instead, we elect representatives who, in budget deliberations, must consider competing interests and reach compromises. Taxpayers want health benefits for themselves and their family members, but they do not always want to finance them for others. The question is, should the cost of health care be borne by the patient, the family, neighbors, church and civic groups, or local, State, and Federal governments? In other words, should the cost be distributed as widely as possible, or should it fall to the patient to pay?

Will our system need to ration care? This is a question that evokes emotional responses but little consensus. The answer depends on how you define "rationing." At its worst extreme, rationing could mean withholding treatment from any person whose prognosis for recovery is poor or for whom the cost of care is high. Rationing could mean simply waiting for nonemergency elective hospital admissions rather than building additional hospital beds. Rationing, in a publicly funded program or in a privately financed insurance program, could mean excluding nonessential services from coverage, or limiting the amount, duration, and scope of some services. Rationing exists when we do not routinely provide health care to the working poor and unemployed who do not qualify for governmental programs. Rationing makes no sense when we employ heroic measures at any cost to premature infants whose outlook is grim, but fail to provide basic services to poor children and adults with treatable but potentially disabling conditions.

Rationing is determined by availability of funds and the priorities we set for those funds. Rationing clearly has long-range implications that cannot be ignored.

For Medicaid, several key decisions helped shape the program's impact on government:

- Costs were shared between Federal and State governments.
- Poorer States received more funds.
- A minimum package of services was mandated with a large number of optional services available.
- Minimum categories of eligibles were covered by mandate with numerous categories left to the States' option.
- Once enrolled, it was "all or nothing." States could not arbitrarily limit the amount, duration, or scope of services by eligibility category. The program was an entitlement program with no arbitrary limit on expenditures.

Medicare's uniform eligibility and benefit package would seem to be more equitable and easier to administer than the 54 State Medicaid programs. However, aside from the inequities of program coverage and eligibility requirements from State to State, distinct advantages to State-administered programs exist in other areas. States are more visible, and therefore more accountable, to the public than the fiscal intermediaries in the Medicare program. Also, States have the opportunity to experiment with programs tailored to their individual needs and unique circumstances.

By not requiring uniformity among the States, the Federal Government avoided the initial costs of bringing poorer rural States up to the standards of richer industrial States and allowed States to set their own pace for expansion. But by requiring States to determine eligibility relative to payment levels for Aid to Families with Dependent Children, Federal policy indirectly required the States to increase those payment levels if the States were to benefit from expanded Medicaid participation. This has become a deterrent to States as they attempt to enroll more of their working poor or unemployed residents under Medicaid.

There are only two options in financing Medicaid: either more Federal funding or more State funding. Neither seems very attractive to the affected parties. A "cap" on Federal expenditures for Medicaid negates the entitlement nature of the program, and if we artificially limit Federal responsibility, we force the States to choose between cutting back programs, to live within the cap, or making up the shortfalls with State funds. Increased Federal funding is not likely in light of the Federal budget deficit, but it is to Medicaid's credit that a Federal cap has not been enacted in spite of the Federal budget deficit.

The indigent who do not qualify for Medicaid, but who do require health care, will most likely receive it in some fashion, and that cost will be borne by State or local taxes or by shifting costs to private payers. These become "underground" health care costs, never voted on or properly managed. So when we speak of capping Medicaid, we are in effect considering an option that would force more people into this informal, inequitable, and inefficient system (or nonsystem) of health care delivery and financing.

It is tempting to pursue whatever cost-containment strategies are fashionable at the moment and abandon other simple but effective means of controlling costs. This has its dangers when policymakers and program administrators act in haste and assume that there are single solutions to the complex problems of rising health care costs. Not all strategies are transferrable from one segment of society to another. What may be cost effective for workers and their families may not be appropriate for the mentally retarded or the frail elderly.

In some strategies, such as prepaid or capitated plans where quality of care is considered by some to be at risk, it is desirable for such service delivery systems to be tested on the general population rather than experiment with the poor and dependent. If these new ventures are satisfactory and acceptable to the population as a whole, then publicly supported programs can buy into them.

Ideally, Medicaid administrators should pursue ways of achieving efficiency and effectiveness routinely, not only in times of fiscal crisis. In doing so, a broad range of strategies would be employed with sufficient experimentation and evaluation prior to wide-scale implementation.

In the past, increases in Medicaid budgets have far outstripped increases in State revenue growth to support them. Yet States have continued to meet their obligations while striving to bring the rates of increase down to more manageable levels.

Implications for the future

Concerns about the elderly and disabled have taken a back seat to the Nation's absorption with the Federal budget deficit. Continued delays in exploring restructuring options and alternate financing arrangements will prove costly in both the short and long run.

Medicare program expansion need not be totally at public expense; options could be offered to beneficiaries based on their interest and willingness to pay. Private long-term care insurance should be aggressively pursued; a voluntary Medicare—Part C could be added to finance a long-term care insurance pool.

In exchange for mandatory assignment for physician payments, beneficiaries may be willing to pay graduated levels of deductibles, according to their ability to pay, especially if excesses within supplemental insurance policies were also eliminated. The current direction of requiring increased beneficiary financing, without improving the less-than-adequate benefit package, undercuts the value of Medicare to beneficiaries and diminishes support for the program.

It is difficult to draw accurate comparisons with other nations on how they meet the needs of their elderly. Family size and structure, location of relatives, age of elders, "position" in the family according to culture, religion, and the simple economics of divisions of labor all contribute heavily to the policies that ultimately shape each nation's response.

Any single set of standards could not be transferred easily to, or successfully imposed on, the many diverse cultures residing within our borders. Although we should try to draw lessons from other nations, we must rely on our merged heritage of resourcefulness and compassion to shape America's health policies.

During the past 4 years, the Nation has stood at several major crossroads concerning Medicaid; there have been repeated attempts to "cap" Federal funding as well as a rather short-lived proposal to federalize a portion of the Medicaid program. If both of these directions were permanently abandoned, the next direction the program might take would be to ease Medicaid eligibility rules to allow coverage of more of the country's poor families and individuals.

To afford this, the pressures on the Medicaid program as the sole financier of long-term care services for the elderly and disabled would have to be eased. Concern over expenditures, if not allowed to paralyze us, can inspire us to find innovative ways of financing our future needs, without total reliance on public funds, and delivering necessary services in the least restrictive and most effective way.

As important as cost containment is, we must devote more attention and resources to promoting wellness, preventive care, and early diagnosis and intervention, especially in the provision of prenatal care. Teenage pregnancy, sexually transmitted diseases, and substance abuse all cry out for attention. To ignore them is to invite costly consequences, most of which will become Medicaid liabilities.

During the past 20 years, health care, as a business, has enjoyed the best of all possible worlds. It was seen as a respected healing art, not as a profit-motivated business. Decisions made by health care professionals were rarely questioned; prices were discussed even less frequently. More was always better; patients expected and demanded the best and most at any cost, and they paid very little of it themselves. Even physicians all too often were unaware of the cost of the services they ordered. Anything less than "heroic" medicine was thought to be unacceptable when life itself hung in the balance.

When Medicare and Medicaid were enacted, the climate was such that Government bowed to the medical professions and eagerly sought their support and approval. Today, we value the medical profession for its skills, its ingenuity, and its compassion, but we recognize that it is a business, and that, as a business, it will respond to the market pressures and incentives that we create. It seems likely that Government will take a more aggressive role in the future in its negotiations with the health care professions.

What remains to be decided for ourselves, our parents, and our grandparents, as well as for our children and grandchildren, is how we will share the financial responsibility for meeting the essential needs of the poor, the handicapped, the unemployed, the frail elderly, and the chronically ill.

blank page

J. Alexander McMahon

J. Alexander McMahon is President of the American Hospital Association, a position he has held since November 1972. He graduated from Duke University and Harvard Law School. He was Chairman of Duke's Board of Trustees for 12 years. He was formerly President of the International Hospital Federation and served on its Council of Management. He is a member of the National Academy of Sciences' Institute of Medicine. Board memberships include the National Center for Health Education (Vice-Chairman) and 3M Company.

Impact on beneficiaries

There is no doubt that during the past two decades the Medicare program has done much to reduce financial barriers to access to state-of-the-art health care services for the elderly, the disabled under social security, and persons with end-stage renal disease. This represents an enormous accomplishment for society.

Although much has been accomplished, much still remains to be done. The current Medicare benefit package is fragmented as well as difficult to comprehend and administer. As a result, the beneficiary often feels trapped in an administrative maze, unaware of what services are covered and what is to be paid, to whom and by whom. Recent changes in Part B and the procedures for appeals to Peer Review Organizations have compounded this basic problem.

Another important issue is that the benefits of the program reflect the knowledge, wisdom, and needs of the mid-1960's when the program began. Much has been learned since then and the needs of the population have changed, yet program benefits have not evolved at an adequate pace. This is particularly apparent for long-term care, care of the chronically ill, and benefits for physician services.

Finally, the program has not done enough to safeguard the most vulnerable of our citizens—the poor elderly. This population group has special needs that must be recognized and met. Old answers will no longer suffice. Instead, creativity must be brought to bear in designing and administering Medicare benefits for these citizens.

Despite these shortcomings, the program has succeeded in ensuring access to health care services for millions of people. In the process, it has helped improve the overall health status as well as the quality of life for the Nation's aged.

During the same period, the Medicaid program has reduced financial barriers to access to health care services for millions of economically disadvantaged people throughout the Nation. Moreover, because an insurance mechanism has been used to provide access to care, Medicaid beneficiaries have been able to obtain care with dignity. Like Medicare, the Medicaid program represents an enormous accomplishment for society as well as a promise that must be kept.

Although the Medicaid program has accomplished much, it has not been devoid of problems. Clearly, there have been administrative and fiscal difficulties, resulting in the inability to fulfill completely the promise of Medicaid. Three major types of problems have affected the people the program was intended to assist.

First, the criteria and procedures for obtaining and maintaining eligibility, as well as the content of the benefit coverage itself, have been extremely difficult for beneficiaries to understand. This problem is compounded for those beneficiaries relocating to other States with different eligibility and benefit coverage rules.

Second, cost-sharing features, as well as benefit limitations applied by individual State Medicaid programs, can represent a significant barrier to care for those eligible.

Finally, depending on a State's budget constraints and competing social priorities, many of the economically disadvantaged may not meet the eligibility criteria for Medicaid coverage, yet they are unable to afford private health insurance coverage. Thus, many economically disadvantaged people may be "falling through the cracks" of the Medicaid system, not seeking care when it is needed.

Like the Medicare program, the funding, eligibility, and benefit design features of the Medicaid program reflect in many cases the knowledge, needs, and economic environment of the mid-1960's. Much has been learned and much has changed in the last two decades. In reassessing the Medicaid program, along with other social welfare programs, the changing size, characteristics, and needs of the economically disadvantaged must be considered. Yesterday's solutions will not answer today's and tomorrow's problems and concerns. Despite its shortcomings, however, the Medicaid program has succeeded in helping to provide dignified, high-quality health care services for millions of people, improving their overall health status and quality of life in the process.

Impact on health care providers

The fee-for-service and retrospective cost-based reimbursement mechanisms woven into the original fabric of the Medicare program were entirely consistent with the original, overriding objective of the program to expand beneficiary access to health care services. Combined with the relatively rich benefit coverage provisions of the program, there were incentives for both providers and beneficiaries to provide more care, and more sophisticated care.

Over time, as Medicare program outlays exceeded the original estimates, a variety of regulatory measures were undertaken to restrain increases in payments to providers from the hospital insurance trust fund. For hospitals, this meant an increasingly complex, sometimes contradictory and arbitrary, array of control mechanisms, growing administrative burdens, decreased management flexibility, and continued tinkering with the payment system without any fundamental changes in incentives.

Various elements of allowable costs were selectively redefined, such as elimination of the "2-percent factor" that was intended by Congress to provide an operating margin factor for not-for-profit hospitals, redefinition of reimbursable malpractice costs, and reduction and eventual elimination of the nursing salary cost differential—an additional payment designed to recognize the greater nursing care requirements of elderly patients. Reasonable cost limits, established for Medicare routine nursing care costs per diem, were tightened over time and eventually were expanded to include all operating costs and were applied on a per-case basis. Professional standards review organizations, established to monitor the medical necessity and appropriateness of care, operated unevenly with unclear objectives and guidance. The Medicare program also entered into contracts with States to review and approve capital expenditure projects and, eventually, separate Federal health planning legislation was enacted that provided for financial sanctions to States that chose not to establish certificate-of-need programs meeting detailed, prescriptive Federal requirements.

All this tinkering yielded little productive good, and for hospitals, it resulted in increased regulatory and administrative burdens and a no-win situation. If hospitals reduced their costs, they were merely paid less. If costs exceeded the mechanically set limits, hospitals were penalized, not necessarily because of performance, but because of inequities in the formulas used to set the limits.

In the last several years the Medicare program has changed its strategy. Repressive controls have been replaced with dynamic incentives. The keystone in this changed strategy has been the prospective payment system. Nonetheless, the mechanics of prospective payment will need to be modified and refined as more is learned about the total effects of its operation. The considerable promise offered by the early experience under the program is threatened by the fact that the system is becoming very complicated. The incentives of the system could be sapped if hospitals cannot predict the price they will receive for their services or if the price is inadequate.

Medicare prospective payment, in combination with changes in private health benefit plans designed to increase patient cost consciousness, medical technology, consumer preferences, and patterns of practice, has produced dramatic results. During calendar year 1984, total hospital expenses rose only 4.5 percent. This was the lowest growth rate in 22 years, and less than one-third of the rate of increase 2 years ago (15.8 percent) and less than one-half the 1983 rate (10.2 percent). Inpatient expenses in 1984 increased only 3.2 percent. Medicare expenditures increased at the lowest rate since the inception of the program.

The dramatic slowing of the rate of increase in costs is largely the result of three factors. First, admissions have declined sharply for both the 65 years of age or over group and the under age 65 group. Second, average length of stay declined significantly. Although lengths of stay have been declining for many years, recently the rates of decline have accelerated. In 1984, the length of stay of patients under age 65 was 3.6 percent lower than the previous year. The length of stay of patients 65 years of age or over declined 7.6 percent between 1983 and 1984. The third major factor responsible for slower growth of expenses is a reduction in hospital employment, made possible not only by lower admissions and lengths of stay, but also by staffing efficiency improvements. Although full-time equivalent employment increased at rates of 3.7 and 1.4 percent in 1982 and 1983, respectively, full-time equivalent employment declined 2.3 percent in 1984.

Continued improved performance can be expected in the future. With a Medicare population that is growing both in size and age, however, it is unrealistic to expect total Medicare expenditures to decrease. A larger and older population will require more services, services that must be provided if the promise of Medicare is to be fulfilled. If these growing demands are met by underpayment to providers, any short-run savings obtained would be at the long-run expense of reduced access of beneficiaries to state-of-the-art medical care. Such a scenario is unacceptable. Avoiding this outcome is possible, but it will require a firm recommitment to the basic principles that guided the original development of the program.

When Medicaid was enacted in 1965, the fee-for-service and retrospective cost-based reimbursement mechanisms woven into the original fabric of the Medicare program also became part of the Medicaid system. As was the case with Medicare, these payment mechanisms were not only entirely consistent with, but also actively supported the Medicaid program's objective of expanding access to health care services to a previously underserved population.

As the Medicaid program moved from a concept to a reality, and as program expenditures began to exceed the original budget estimates, States began to adopt many of the same regulatory measures undertaken by the Federal Government to restrain increases in Medicare provider payments. Some State Medicaid programs also added their own unique cost-containment provisions. As was the case with Medicare, all this tinkering yielded little productive good.

With the enactment and implementation of the Omnibus Budget Reconciliation Act of 1981, States were given broader discretion in structuring their provider payment methods, as well as program eligibility and benefits. The results of these structural changes have been mixed, coming at a time of high unemployment and substantial Government budget deficits. Some States appear to be trying to use this new-found flexibility imaginatively, tailoring eligibility and benefit coverage to those most in need and changing the basic incentives in provider payment arrangements. Experiments in per case and per capita fixed-price payment systems and case-management delivery arrangements are increasingly common, as are selective contracting and preferred provider approaches. In some States, however, the changes appear to have been more arbitrary, such as across-the-board budget cuts, with eligibility and benefit coverage substantially reduced and provider payments frozen or capped.

Where imaginative State Medicaid programs have been developed, it is reasonable to expect that these programs, in combination with Medicare prospective payment, more demand-sensitive private sector health benefit plans, and changes in medical technology, consumer preferences, and patterns of medical practice, have helped to produce the dramatic cost-control results now being seen on an aggregate level. Because of improved overall cost performance, some States have been able recently to increase their eligibility and benefit coverage.

However, in those States where eligibility, benefit coverage, and provider payments have been substantially reduced, problems inherent in underfinancing, for both providers of care and the economically disadvantaged, are growing. In some communities, the problems are, in fact, reaching crisis proportions. The total amount of uncompensated care provided by hospitals (the sum of bad debts and charity care) doubled between 1979 and 1983, from about $3.9 billion to about $7.8 billion. Public hospitals, in particular, have provided an increasing proportion of this care. Public hospitals, however, are not alone. As a group, private hospitals have provided the bulk of uncompensated care. Also, the financial problems of uncompensated care have not been limited to either the inner cities or the industrialized Northeast. As a percentage of gross revenues, uncompensated care has been highest in the South and Southwest, regions generally characterized by relatively limited Medicaid programs, relatively lower rates of private insurance for the employed population, and, until recently, relatively low income levels.

The problem of uncompensated care is compounded by the fact that hospitals with high proportions of uncompensated care and Medicaid patients already tend to be in financial distress. Further, although more market-oriented, incentive-based financing and payment systems are already demonstrating their effectiveness in containing costs, uncontrolled price competition will tend to exacerbate the financial problems of hospitals providing care to the poor, unless explicit measures are taken to ensure adequate and equitable financing.

Impact on government

The substantial progress that the Medicare program has made during the past 20 years in ensuring the availability of high quality health care for millions of elderly and other citizens has come about at no small cost. However, with a goal of assuring that services were available and accessible to the elderly, this cost was unavoidable.

The problem has not been so much the cost of the Medicare program, but rather that the costs were originally underestimated and other demands on national resources are being met at the expense of social welfare programs.

Underfinancing of the Medicare program through unrealistic reductions in benefits or provider payments, although producing the illusion of savings, is actually a cost-increasing strategy in the long run. Underfinancing is a strategy that the Nation cannot afford, particularly as the Medicare population grows both larger and older. It is unaffordable both in monetary terms and in terms of the effect it will have on our basic social fabric and values.

In lieu of underfinancing must come a full re-examination of the policies that have guided the financing of Medicare. Such a reexamination has been done with respect to hospital payment. The result has been a new approach to payment that has performed well to date and holds great promise. The same imagination and creativity must now be applied to other components of the financing side of the equation.

Medicare financing must be fundamentally reexamined, based on the principles of pluralism, consumer preference, and equity. Equity and uniformity are not synonymous terms, and it is only by reforming the Medicare financing system that the social contract that the Nation made with its elderly can continue to be honored.

As with Medicare, the progress that the Medicaid program has shown in making health care services available and accessible to the economically disadvantaged has cost more than originally estimated, leaving the impression that the program has cost more than it should. In addition, other demands on Federal, State, and local government resources have placed unrealistic pressures on many domestic programs. As a result, both Federal and State governments have sought Medicaid expenditure reductions and savings wherever possible, at times arbitrarily.

Although the original intent of the Medicaid program was not necessarily to meet all the health care needs of all the economically disadvantaged, there are growing concerns that reductions in eligibility, benefits, and provider payments have been so drastic that many citizens feel they no longer have access to health services, except in life-and-death circumstances. County and city governments, as well as individual hospitals and other providers that have traditionally cared for the economically disadvantaged, increasingly find themselves unable to fill the growing gaps and increasing needs. At the same time, private payers and purchasers of care, which are health maintenance organizations as well as self-insured businesses, Blue Cross/Blue Shield plans, and commercial insurers offering more traditional health benefit plans, have been seeking to limit their own payment liabilities and prevent cross-subsidization of uncompensated care costs. These limitations are compounded by underpayments by State Medicaid programs.

Health care and other leaders in a number of States are currently seeking to develop humane, compassionate strategies for filling the gaps in their current Medicaid programs. At the national level, policymakers will need to monitor this activity closely, learning from both successes and failures. National policymakers must also examine the Federal Government's own role in financing care for the economically disadvantaged and create new answers—matched to the needs of the new economic and demographic realities.

In the broadest sense, the success of any Nation may be gauged ultimately in terms of how well it addresses the needs of its disadvantaged. The issue of adequate and equitable financing of health care services for the economically disadvantaged requires a full reexamination of the policies that have guided the financing of Medicaid. Such a reexamination will require considerable imagination and creativity and, as in the case of Medicare, must be based on the principles of pluralism, consumer choice, and equity. "Choice," however, does not necessarily mean unlimited choice, nor does "equity" necessarily mean uniformity.

Implications for the future

The Nation is approaching a major crossroads with regard to the Medicare program as a result of the Federal budget deficit, competing defense and domestic priorities, and a slowly improving, but fragile, economy that requires fundamental retooling and redirection.

Whether the Medicare program is viewed by the Congress and the general public as a continuing, significant part of the problem and solution to the Federal budget deficit will have a major bearing on the program's future policies and outcomes. If recent and additional reforms in benefits and provider payment systems were to be "over-worked," such that they become reforms in name only, aimed at producing more and more short-term cost savings, the types of access and care to which middle- and low-income beneficiaries have become accustomed would surely change. The changes in many cases would be gradual, but ultimately their aggregate effect would be viewed as sufficiently unacceptable, to both beneficiaries and others, to create a backlash of ill-will toward the program and the Federal Government.

I remain confident that the Federal Government will avoid the temptations and dangers of underfinancing. I also remain confident that the equity questions in payment and broader financing reforms can and will be resolved satisfactorily.

Although the American Hospital Association (AHA) has not yet adopted a specific position on long-term reform, several measures in combination need to be considered seriously as a Medicare reform package:

- Raising the age of eligibility for Medicare benefits by tying it to the age of eligibility for social security benefits.
- Merging existing deductible and copayment provisions under Part A into an all-inclusive deductible, with a partial or total waiver of the deductible for beneficiaries enrolling in various capitation-payment-based organized delivery systems—health maintenance organizations, competitive medical plans, and other new mechanisms that can be identified. The notion of merging Parts A and B also merits attention.
- Increasing or removing the taxable income limit on the hospital insurance trust fund component of the Federal Insurance Compensation Act (FICA) tax, so that higher income workers contribute more to the fund for their future benefits.
- Within the personal income tax system, establishing a Medicare premium contribution by current beneficiaries that is sensitive to differences in their income, with the revenues earmarked for the fund. This approach would take into account the fact that current beneficiaries, during their working years, have contributed far less to the fund than the actuarial value of their current benefit coverage.
- Increasing, and earmarking for the trust fund, Federal excise taxes on selected goods and services, such as alcohol and tobacco, whose voluntary consumption has an adverse effect on health status and contributes to the cost of the Medicare program.

For Medicaid, the Nation is approaching a major crossroads on the broader issue of financing care to the economically disadvantaged. The American Hospital Association has identified financing care for the indigent as its most critical issue for study and resolution. Our Board of Trustees has established a special committee on this issue, and our House of Delegates has adopted an interim position pending the outcome of the special committee's work. Importantly, this position states that the individual self-interests of government and private payers, businesses, providers, and consumers must be held in balance with broader community and society interests, so that needed care is assured for all people. Ultimately, this issue will only satisfactorily be resolved through the ongoing commitment and cooperation not only among Federal, State, and local governments but also including private payer, business, labor and provider forces within each community. These forces must join together in ways that are uniquely tailored to local circumstances to create and sustain lasting solutions.

Although the total solution will not come from reforming government programs, it must play an important part. The AHA's special committee and other groups must, in their search for answers, develop specific recommendations on needed reforms in the structure of the Medicaid program, including such matters as adequate minimum funding levels, minimum eligibility standards, cost-conscious benefit design, and administrative flexibility.

The fundamental matter of the appropriate future roles and responsibilities of Federal versus State government must also be examined. Other important decisions to make include:

- Whether certain groups of the economically disadvantaged are the particular responsibility of government, and at which level of government.
- Whether certain types of services are more necessary than others for certain segments of the economically disadvantaged.
- Whether and what limitations on choice of delivery settings and arrangements might be appropriate.
- Whether other Federal policies and programs, e.g., Medicare, tax code provisions on charitable contributions, or Aid to Families with Dependent Children, need to be modified simultaneously with any Medicaid reforms to achieve better coordination and synergism.

The foregoing is obviously not an exhaustive list of the issues and concerns; it is simply a starting point for addressing what must come to be understood as one of the most critical issues on the Nation's domestic policy agenda.

blank page

Vita R. Ostrander

Vita R. Ostrander is President of the 20 million member American Association of Retired Persons. She is a member of the U.S. Committee of the International Council on Social Welfare and the Consumer Advisory Committee of the American Health Care Association. She is also on the editorial board of the ***Journal of Gerontological Nursing****. Mrs. Ostrander has a nursing background with 10 years' employment with the American National Red Cross in disaster relief, the blood program, and hospital and field services operations. For 30 years she has been a volunteer leader in health, legislative action, and older women's and consumer affairs.*

Impact on beneficiaries

Few today would argue with the assertion that the Medicare and Medicaid programs have had a profoundly beneficial effect on access to health care by the elderly, the disabled, and the poor, and that, together, the two programs have significantly alleviated the financial burden borne by these people in meeting their health care needs. Nevertheless, significant numbers of elderly, disabled, and poor persons are at risk for sizable out-of-pocket health expenses or, in some cases, may even have to forego medical care because of incomplete and variable levels of health care coverage.

Designed to facilitate access to acute care medical services, the Medicare program, which served 19 million older Americans in 1966, today serves 28 million, (about 98 percent) of the elderly population in this country. A significant subpopulation of this group (about 15 percent) also receives Medicaid benefits.

Since 1966, the portion of the elderly's health care bill covered by Government spending has almost doubled, while that portion paid directly by the elderly themselves has been reduced by half. Further, elderly persons, who prior to the establishment of Medicare were spending roughly 15 percent of their annual income on health care, experienced a substantial decline in this category of household expenditure within a few years of the full implementation of the Medicare program.

Moreover, from a review of life expectancy and mortality rates over the last two decades, we can infer a considerable degree of correlation between greater access to health care and improved health status of the elderly. Not only do we see improvements in life expectancy and mortality rates; the increased availability of such therapeutic surgical interventions as lens implantation and hip replacement under the Medicare program has done much to enhance general functional levels and quality of life for hundreds of thousands of older Americans.

Notwithstanding the impressive accomplishments that have been facilitated in no small part by the Medicare and Medicaid programs, it would be a distortion of fact to suggest that older people are now somehow insulated from the high cost of health care. Indeed, much of the protection originally afforded the elderly by these two public programs has gradually been eroded over time. Today, Medicare covers less than one-half of the elderly's health care bill. Although Medicaid picks up another 14 percent, the beneficiary is responsible for fully one-third of the total, either directly out of pocket or indirectly through supplementary medical insurance and/or private health insurance premium payments.

Today, in fact, older beneficiaries spend as large a portion of their income on their health care needs as they did before the existence of Medicare. Moreover, out-of-pocket medical expenditures for older Americans continue to rise at a faster rate than do their incomes; such expenditures are expected to consume, on average, almost 20 percent of elderly annual income by the year 2000.

Tracing the arc of Medicare and Medicaid protection, one finds troubling irregularities and gaps. Although Medicare coverage of hospital costs is relatively complete (75 percent), the older beneficiary is vulnerable to considerable, and frequently unpredictable, liability for physician services. In 1983, elderly beneficiaries were responsible for more than $7 billion in physician charges alone. Further, Medicare provides only minimal coverage for skilled nursing services, and offers no coverage for long-term nursing care, prescription drugs, dental services, and optical supplies. Medicaid's coverage of long-term nursing care, which requires virtual impoverishment as a condition of eligibility for benefits, still leaves the beneficiary at risk for roughly one-half of the total nursing home bill.

One of the most disquieting aspects of the inadequacy of Medicare coverage for the elderly today is that it tends to disproportionately burden the poor elderly, the sick elderly, and the very old. About one-fifth of all Medicare beneficiaries depend exclusively on Medicare for protection against medical costs. These people, who are likely to be over the age of 75 and in the lower reaches of the income scale, are most vulnerable to increases in health care costs in general and in Medicare cost-sharing requirements in particular. Further, out-of-pocket expenses expressed as a percent of income are six times greater for poor and near-poor older people than for their middle-income counterparts.

Moreover, although Medicaid has done much to improve access to health care for poor and near-poor people, the program covers only 35 percent of the age-undifferentiated poor and near-poor population. About 15 percent of the poor and near-poor have no form of insurance coverage. Research on the health care utilization patterns of this population suggests that many of its members who are sick have no choice but to forego medical care.

The magnitude of the Federal budget deficit, the projected insolvency of the Medicare hospital insurance trust fund, rising health care costs, and the resource implications of an aging population have conspired to make the Medicare and Medicaid programs prime targets for budget cuts. Preoccupation with such concerns is redirecting emphasis away from the earlier programmatic goal of eliminating inequities in access to medical care toward the goal of containing costs. Traditionally, efforts to control costs have taken the form of increased beneficiary cost-sharing or, in the case of Medicaid, revised eligibility requirements and benefit reductions.

From the beneficiary's standpoint, such approaches are shortsighted and narrow. The persistence of budgetary dilemmas and the inexorable change in demographic patterns must inevitably lead to a reconsideration of the design of the health care system, both in terms of service delivery and financing. The heterogeneity of an aging population dictates the development of a delivery system and financing mechanism that are particularly flexible and responsive to the long-term chronic care needs of its members; redirect the existing bias in favor of institutional care toward care in the community; and fill existing gaps in health care services. Whatever the outcome of the inevitable debate over the structure and funding of such a system, issues of quality of care and quality of life must not be subordinated to issues of cost.

Impact on health care providers

Medicare and Medicaid policies have had a profound impact on the shape of the health care delivery system. In the future, Medicare and Medicaid policies will be the linchpin in refocusing the delivery of care from institutional settings to community-based ones.

To assure financial access of the elderly and the poor to acute medical care, benefits and reimbursement under Medicare and Medicaid have heavily favored hospital care; this has led to excessive inflation in hospital costs and over-expansion of the hospital industry. Under cost-based reimbursement, hospital management has had little incentive for operating efficiently since it was pointless for management to hold the line on operating costs when the end result was a reduction in the institution's revenues. Because depreciation and interest expenses, along with operating revenues generated by capital improvements, were passed on to Medicare and Medicaid without penalty, hospital expansion flourished. In fact, capital payment provisions discouraged institutions from closing underutilized capacity because depreciation payment and cash flow would decrease.

With the financial risk of carrying long-term debt removed, the debt market replaced philanthropy as the principal source of capital funding. In addition, generous return-on-equity payments for investor-owned facilities resulted in rapid growth of for-profit institutions in an industry traditionally concentrated in the nonprofit sector. No longer were hospitals community providers of social goods dependent upon community support; they became instead businesses with sophisticated accounting practices competing in the debt market.

Physician reimbursement under Medicare and Medicaid reinforced the use of the hospital as the provider of first choice. Medicare's usual, customary, and reasonable charge-based methodology was inherently inflationary; it also provided more generous reimbursement for physician services performed in the hospital than for services provided in outpatient settings. Since Medicare paid hospitals for graduate medical education, physicians in training learned hospital care, not ambulatory or long-term care, thus impeding the development of geriatric medicine. Moreover, payment was exclusive to physicians, hindering the use of alternative health practitioners. Medicaid's payments to physicians have been set so low that many physicians refused to treat Medicaid recipients, forcing persons with low income to rely upon hospital outpatient departments and emergency rooms for their care.

Payment policies dramatically influenced the adoption and use of new technology. Since payment levels for the introduction of complex and expensive technology have been disproportionately high, there has been little incentive to evaluate appropriate indications for the use of new technology, to substitute less costly technology, or to adjust payment levels downward as the cost of technology declines over time. The result has been tremendous reliance on the use of specialized, procedure-oriented care rather than cognitive and preventive services.

Benefits and reimbursement for long-term care also favored institutional care, spurring rampant growth of the nursing home industry, particularly the for-profit nursing home. Consequently, well-developed, community-based systems of care have not developed, even though these systems have been found to be cost effective and to better meet the elderly's long-term care needs.

Recognizing the inefficiencies of past policies, the Federal Government, through a variety of financing changes, has begun to place limits on available funds to provide care. For Medicare, the most dramatic change has been the implementation of the prospective payment system and diagnosis-related groups (DRG's); for Medicaid, it has been reductions in Federal matching payments and State experimentation with alternative payment mechanisms. Hospitals must now consider the bottom line and control costs. However, because of uncertainty about future increases in Government financing of care for the elderly and the poor, hospitals serving a disproportionate share of these patients face financial uncertainty while hospitals, primarily investor-owned, serving better financed, privately insured patients, continue to flourish.

Medicare DRG's could profoundly affect the adoption and use of new technology. Since high technology care (such as intensive care units) becomes a revenue-loser rather than a revenue-enhancer, many hospitals may begin to provide only those services and technologies that promise adequate revenues. And, as long as physician payment continues to reward the use of complex technologies, the development of "mini-hospitals" with physician offices and ambulatory care settings will most likely expand.

Medicare and Medicaid have begun to experiment with capitation, and Medicaid has provided waivers for community-based systems of care. Although home health care and health maintenance organizations were already experiencing unprecedented growth, the Government's entrance into these alternative systems of service delivery will accelerate their expansion. Still, public financing for alternative care arrangements has been slow in coming, and large gaps remain, especially in preventive care, geriatric medicine, community-based long-term care services, and the use of alternative care providers. As institutional and highly technical care is down-sized in response to Government restrictions on funding, many elderly and the poor will be faced with a lack of needed alternatives unless these gaps are closed.

Impact on government

Key decisions in the design of Medicare and Medicaid have shaped the impact of these programs on governmental expenditures. The payment mechanism in Medicare and the broad range of eligible populations in Medicaid have driven Federal expenditures far beyond original projections of program costs in 1965.

The greatest flaw in the design of the Medicare program was the decision to pay hospitals the costs incurred in treating Medicare inpatients and to pay physicians a fee for each service performed. These payment mechanisms are inherently inflationary and have contributed to the relentlessly high rate of inflation in the health care sector of the economy during the past 20 years. It is important to remember, however, that before the establishment of Medicare, millions of elderly people could not afford medical care. Despite its flaws, Medicare has been a huge success. It has provided care for millions who otherwise could not have afforded health care, and in the process has contributed to an almost 5-year increase in the average life span of American citizens.

The greatest flaw in the design of the Medicaid program is of a different character since each State has considerable discretion in establishing its Medicaid reimbursement procedures. The single most important factor influencing Government expenditures in the Medicaid program is the cost of institutional long-term care. The largest share of Medicaid expenditures and the greatest acceleration in program costs have occurred in the provision of institutional long-term care services for both the functionally impaired elderly and disabled as well as the mentally retarded.

From the beneficiaries' point of view, there are profound strengths in the design of Medicare compared with the design of the Medicaid program. The fact that Medicare is a relatively uniform, national insurance program, benefiting a broad cross-section of our society, is a major strength of the program. Medicaid, on the other hand, is not a single unified program, nor even 54 uniform State and territorial programs, but a collection of programs in each State incorporating multiple objectives, target populations, and services in an uneasy, and often antagonistic, relationship.

The experimentation inherent in 54 different State and territorial Medicaid programs is, some believe, an important strength of Medicaid. Medicare, however, has allowed waivers from program requirements since the program was initiated, and thus has been able to experiment and demonstrate a variety of ideas under various waiver authorities. Hence, experimentation is a strength of both programs.

Improving Medicaid will require major structural changes in the program. The national experience with Medicaid underscores the fact that the basic health care needs of individuals and families are fundamentally different from the social and health needs of people with chronic functional impairments. The American Association of Retired Persons questions the efficacy of continuing to finance and administer preventive and acute medical care and long-term maintenance care for disparate target populations within a single program.

Eligibility for preventive and acute care services for the poor and near poor ought to be based on uniform national standards, not 54 different State and territorial standards. Within broad Federal guidelines, States should be able to set up a balanced long-term care system, including community and home-based care services as well as institutional long-term care services.

Medicaid's reliance on States' generosity (or lack of it) to fund the program at an adequate level has labeled it as a welfare program for the poor. Welfare programs have not fared well in both State and Federal Governments' budget-cutting environments. The fact that Medicare is financed, for the most part, through the payroll tax is an important strength of the program.

The most important issue concerning the current financing of Medicare is whether our society will be able to control the rate of inflation in the overall health care sector of the economy. If not, there will continue to be great pressure for major structural changes in the Medicare program. Proposals to "solve" the Medicare problem solely within the boundaries of the program, without addressing the cost problems of the overall health care system, would so erode Medicare coverage that beneficiaries would ultimately receive little benefit from the health insurance that they had paid for during their working lives.

Even assuming moderation in the rate of growth in the health care sector overall, it is likely that the level of payroll taxes financing Medicare will not be sufficient over time to cover program costs. The Association supports raising the excise taxes on tobacco, and earmarking the additional revenue for the hospital insurance trust fund as a prudent way of increasing the fund's long-term solvency.

Relating the beneficiary's ability to pay to the beneficiary's financial responsibilities under the program (i.e., means-testing) is a popular idea in Washington, but not across the country. Beneficiaries already pay huge sums out of pocket for health care. The Association sees no room to both "redraw" the Medicare contract and continue to maintain confidence and trust in the system.

The Association believes that while the encouragement of choice and competition in the delivery of health services must be part of any solution to the health care cost dilemma, any effective program of cost containment must pursue both regulatory and market approaches together. Competition alone cannot be the answer. Not only does the health care market resist normal forces of supply and demand, but the consumer information that is critical in order to assess efficacy and quality of services in a competitive system is severely lacking.

Further, unlimited competition in the health care industry may not serve the American people well. Under competition, health care providers tend to seek out the healthiest, and hence most "profitable," patients. Under competition, patients may face increased cost-sharing and/or restricted freedom of choice. Under competition, the poor and the very sick may have no place to go for medical care.

The Association advocates instead a comprehensive approach to health care cost containment that focuses for the short term on negotiating—or, if necessary, mandating—limits on the rate of increase in payments to providers for all third-party payers, not just Medicare.

Over the long run, health care delivery should be restructured to expand the supply of more appropriate alternatives to hospitals and nursing homes. The development of competing forms of health care delivery such as health maintenance and preferred provider organizations should be encouraged, as should greater reliance on paramedical personnel (i.e., geriatric nurse practitioners and physician assistants), especially in underserved rural and inner city areas.

Implications for the future

This Nation is at a major crossroads with regard to its entire health care system. Over the course of the last two decades, rising health care costs have begun to threaten its commitment to the provision of health care services to all of its citizens—young and old alike. Certainly no one is immune to the insidious impact of escalating medical costs—not workers who face cutbacks in employer-provided benefits, nor the poor of all ages whose protection under the Medicaid program is gradually being eroded, nor older Americans who are threatened with the insolvency of the Medicare program and who continue to face increased out-of-pocket costs. Without a comprehensive restructuring of the health care delivery system, the future availability of effective and cost-efficient health care is certain to be compromised for all Americans.

Since their very beginnings, Medicare and Medicaid have grown to define the Government's basic commitment to ensuring health care for the elderly, the disabled, and the poor. This basic commitment is now in jeopardy because of continuing, excessive cost escalation in the health care sector of the economy and the correspondingly rapid increase in the costs of the Medicare and Medicaid programs. Solutions to these programs' financing problems will require changes in the manner in which all health care services are delivered and paid for.

Today the Nation is facing the same access to care problems that led to the development of Medicare in 1965. However, the current factors tending to constrict access to needed health care services are more numerous and, because they are systemic and complex, less amenable to correction.

The challenge is to guide the restructuring of the health care system to deemphasise its acute care, institutional bias so that the commitment to accessible, affordable health care for all persons is maintained and expanded in areas where needs are not currently being met. In carrying out such a restructuring, the following objectives should be pursued:

- Cost controls must be implemented without sacrificing quality of care.
- Public financing must not be biased toward acute care institutionalization.
- Emphasis and resources must be redirected toward preventive medicine and community-based care.
- Health care resources that are "freed up" through effective regulatory control (and would otherwise have flowed into hospitals) must be redirected to the promotion of less costly alternatives for delivering health care services.
- Artificial and competition-inhibiting restrictions on the use of nonphysician health professionals in the delivery of medical services must be lifted.
- Proposals to increase beneficiary cost-sharing must reflect an appreciation of the growing health care cost burden borne by older Americans.
- Fraud, waste, and abuse must be sought out and eliminated.
- In the pursuit of the foregoing objectives, consideration must be given to the appropriate development and use of medical technology.

As the health care system is being restructured, the programs within that system must be evaluated in order to determine whether they will continue to meet the needs of the people they serve. An increasingly critical deficiency in the present health care system is the lack of comprehensive financing and delivery mechanisms for caring for those with chronic illness or disability.

The dramatic anticipated growth over the next several decades in the functionally dependent population (most of whom will be elderly) is being fueled by five trends:

- A growing aged population.
- Continuing increases in life expectancy.
- Greater prevalence of chronic disease as the dominant pattern of illness for older persons.
- A reduction in the availability of family members to serve as caregivers.
- The Medicare prospective payment system's inherent incentive to reduce the length of a hospital stay.

These trends point to the need for the development of a long-term care program that provides not just institutional care, but a complete continuum of services, including home-based and community-based services. Medicare, it must be remembered, is essentially a health insurance plan for acute illness.

Despite the tremendous need looming in the future, policymakers have been reluctant to approach the difficult issues associated with linking medical and nonmedical services to meet the needs of chronic care patients. In view of the demand for service, however, public sector efforts to establish these linkages must become a national priority, and private sector financing of long-term care services must be encouraged to ensure that adequate resources are available to develop a comprehensive community-based system of long-term care.

In the public sector, establishing the link between health services and the broader range of social and personal services requires changing existing policies. To achieve this link, it is necessary to alter the financial incentives for institutional care that currently exist. By providing institutional care as but one benefit in a case-managed system of long-term care and by providing financial incentives through a prospectively determined amount of funds, in-home and community-based care becomes a more feasible and desirable alternative to institutionalization.

Forging the link between long-term care and related social services must begin in the Medicaid program because it finances almost 50 percent of all long-term care services in the United States. Reforming Medicaid in order to address the long-term medical and nonmedical needs of people with chronic functional impairments will require fundamental changes in the program's structure. In seeking such reform, certain other program infirmities should also be addressed. First, it must be acknowledged that the program has grown to encompass multiple and often disparate objectives and services for vastly different populations. Second, both the financing and delivery systems must control costs. Third, administrative responsibility between the State and Federal Governments should be clearly defined. Fourth, program inequities across States must be reduced.

Finally, no amount of restructuring within the Medicare and Medicaid programs will solve the problems that plague this Nation's health care delivery system. Ultimately, it is the entire health care system that must be redesigned, and the objective of its restructure must be twofold: to ensure the availability of adequate health care and the cost-effective delivery of that care to all Americans, and to redirect resources that are "freed up" through the creation of a more efficient health care delivery system to expand services in areas where needs are not currently being met.

blank page

Uwe E. Reinhardt, Ph.D.

Uwe E. Reinhardt received his Ph.D. in economics from Yale University. He has been on the faculty of Princeton University since 1968, and is currently James Madison Professor of Political Economy. His research interests have centered on health economics. In 1978, he was elected to membership in the National Academy of Sciences' Institute of Medicine. He has served on several governmental task forces on health policy and on several editorial boards including Milbank Memorial Fund Quarterly, Health Affairs, and Journal of Health Economics.

Impact on beneficiaries

Ask a normal human being "How are you?" and you are likely to receive the reply "Fine!"Ask an economist the same question, and the reply is bound to be, "Relative to what?" This is so with perfunctory salutations, and certainly with questions on the impact of the Medicare and Medicaid programs on their beneficiaries. In connection with such questions, one is immediately led to wonder, "Relative to what?"

Those who fought so tenaciously for the two programs during the mid-1960's probably thought of them as logical first steps toward full-blown national health insurance (NHI). Ironically, in retrospect, the two programs may well have deflected American health policy from a path towards national health insurance. With the wisdom of hindsight, the supporters of NHI might now judge these programs as seriously flawed incrementalism, an incrementalism that was just enough to temper the brewing crisis in American health care and divert the Nation's energy from its march towards NHI, but, not enough to free all Americans from anxiety over the financial consequences of illness and grant all Americans access to needed health care on dignified terms.

An argument could thus be made that, relative to a full-fledged NHI program, the Medicare and Medicaid programs actually made millions of the Nation's poor and near poor relatively worse off. This surely must be true of the large number of poor and near-poor Americans who do not now have any health insurance coverage at all, some of whom reportedly are being denied access to health care for want of ability to pay. In its Special Report on this problem, for example, the Robert Wood Johnson Foundation (1983) reported that more than one million families found themselves in that position in 1982. Even the Wall Street Journal (1985), a paper not known for Liberal hysteria, has recently documented cases of gravely ill Americans who have been denied care for lack of insurance coverage and ability to pay. To argue that such families are nevertheless better off than they would be under a national health insurance scheme of, say, the Canadian variety would be to carry ideology to absurd heights.

One can reasonably wonder, however, whether a full-fledged national health insurance program ever has been a realistic option in this country. Quite aside from the Nation's geographic and cultural heterogeneity, its governmental structure—particularly the role interest groups play therein—may well preclude the introduction of so sweeping a social policy as national health insurance. A more realistic baseline from which to judge the Medicare and Medicaid programs may therefore be the situation prevailing prior to 1965. From that baseline, and strictly from the beneficiaries' perspective, one might give the Medicare program the grade of A- and the Medicaid program a plain C, perhaps even a C+.

Whatever shortcomings one may identify in the Medicare program, one would surely not wish to deny that it, along with the entire social security program of which it is a part, has brought about a dramatic improvement in the quality of life of our Nation's senior citizens during the last two decades. As Fuchs (1984) has shown, the average after-tax income per household member of the aged is now about equal to that of the 45-64 years of age group, a fact noted also in the Council of Economic Advisors' *Annual Report* (1985). Before the introduction of Medicare, only one-half of the aged had health insurance, and many of them were quickly driven into indigency when illness struck. Since the onset of Medicare, there has been a substantial increase in the utilization of health services by the aged, most noticeably by the poor aged. If the primary purpose of Medicare has been to bring our aged into the mainstream of American health care, that goal has been reasonably well achieved.

Whether all of the increase in utilization was medically justified can be debated, as can be the precise causal relationship between this increase and the health status of the aged. It is beyond dispute, however, that the increase in utilization has been accompanied by a significant improvement in the health status of the aged, whether one measures it by life expectancy, reductions in age-adjusted death rates, or by age-specific disability days (Fuchs, 1984; and Rogers and Aiken 1984). These improvements in health status are unlikely to have been sheer coincidence.

Yet, unlike the aged in other industrialized societies, our aged still pay for a substantial proportion of their health care out of their own resources. In 1981, for example, Medicare itself covered only about 45 percent of total health care expenditures by the aged. Another 14 percent was picked up by Medicaid, mainly for nursing home care of indigent aged. Fully 36 percent was financed by the aged themselves, either in the form of health insurance premiums or in out-of-pocket expenditures at point of service. For those aged who did use health services, out-of-pocket expenditures averaged between $500 and $600 that year, an amount that was constant over income classes. As a percent of total per capita health expenditures for the aged, these out-of-pocket expenditures ranged from 20 percent for the poor and near poor to 26 percent for those with high incomes.

It can be argued that there is nothing inherently wicked in requiring such contributions from a group whose average per capita income is close to that of the working population and whose financial responsibilities no longer include the rearing and educating of children. The problem is that the averages mask considerable variance. If one man sits on dry ice and the other on a hot stove they can be said to be, on average, comfortable. Similarly, the fact that, on average, the aged may well be able to absorb 20 or 30 percent of the cost of their health care masks the extraordinary regressivity of this cost sharing. For the poor and near-poor aged, out-of-pocket expenses alone represent an average of 14 percent of their already low incomes. To these outlays must be added the health insurance premiums paid by the aged. Health policy analysts and policymakers, who are young and typically find themselves in the upper 10 percent of the Nation's income distribution,[1] are at a serious disadvantage in imagining just what hardship such out-of-pocket expenditures might wreak among poor aged. That is probably one reason why this problem has persisted to the present.

The considerable financial burden the Medicare program still imposes on some of the poor and sick must be counted as one of its major failures from the beneficiaries' point of view—hence the minus on the grade A. It is also a shortcoming from the viewpoint of every American citizen, for a Nation that allows its aged to be utterly pauperized over illness has an image problem in the rest of the world.

A second major shortcoming is the program's benefit structure. That structure places heavy emphasis upon medical episodes requiring short- to medium-term hospitalization, but it leaves unresolved the problem of protecting the aged against the sustained financial drain of long-term chronic illness. In the short run, a solution to this problem will require additional transfers from the working population to the aged. In the long run, the problem must be solved by goading this Nation to a higher savings ratio, that is, by encouraging or even forcing the current working population to set aside now the resources for their own future long-term care.

In thinking about the challenges faced by Medicare beneficiaries in the future, a distinction obviously must be made between individuals who are now aged or near aged and those who will be aged three to four decades hence.

Those now aged or near aged have few options left to rearrange the financial base for their retirement. To the extent that their assets are inadequate to support their years in retirement, they must seek transfers from younger generations. It seems easy enough to provide a moral foundation for such transfers. After all, generations who experienced the Great Depression, who carried this Nation's flag during World War II, who reconstructed their own country and much of the world they liberated with their sweat and ingenuity, and who, in addition, found it in their heart to bestow upon their children the most generous educational benefits any generation has ever bestowed upon another, can without shame expect that those whom they so endowed now return the favor without rancor. Properly viewed, much of what is now deplored by the working young as the insufferable burden of social security is but a repayment for human capital (education) and physical capital (e.g., the infrastructure) that were financed during the working years by those who are now aged.

The challenge faced by those now aged and near aged is to remind the younger generations of these I.O.U.'s in a manner that does not offend the latter's sense of fairness. It is apparent that, at this time, American voters, both young and old, prefer to shrink or at least to constrain the percentage of the gross national product (GNP) diverted to the public sector. Under these constraints, expenditures for the aged do come, in part, at the expense of the younger poor. Already there is evidence that children represent the most rapidly growing segment of this Nation's poor. Among them are the ever-growing numbers of children born to unwed teenage mothers. To neglect the health care and education of these children would be to mortgage the entire Nation. Trade-offs that divert support from these poor to well-to-do aged are apt to violate the sense of fairness of younger adults, even of those who have traditionally been champions of the aged. To quote economist Victor Fuchs (1984), one of the sagest and most humane health economists in our midst: "Twenty years ago the plight of the elderly was palpable. Today the most pressing social needs may lie elsewhere. The 'good society' needs to balance its efforts, to make hard choices among many worthwhile objectives."

Therefore, in seeking to redress the current regressivity of the financial burden Medicare imposes on the aged, those who represent the aged in the political arena should not dismiss, out of hand, a redistribution of economic privilege among the aged themselves. That redistribution could be effected in a number of obvious ways. Unfortunately, a discussion of these options (Davis and Rowland, 1984; and Meyer 1984) goes beyond the space limitation of this commentary.

For those who will be Medicare beneficiaries three to four decades hence, that program and social security in its entirety probably represent a social contract that has outlived its usefulness. That contract needs to be renegotiated, and now would be a good time to start the process.

In contrast to the Medicare program, from the viewpoint of its intended beneficiaries, Medicaid deserves, at best, a mixed review. The ostensible goal of the program was to remove the financial barriers to mainstream American health care for the poor. For some of the poor, that goal has been achieved. Unfortunately, many poor who should, in principle, benefit from the program have been eclipsed by it altogether—hence the relatively low grade C or C+.

---

[1] Only about 10 percent of American families had incomes above $50,000 in 1983.

During the past two decades, there has been a noticeable increase in the utilization of health services by low-income groups. There has also been a dramatic improvement in the health status of the poor. Surely, the Medicaid program can claim partial credit for this achievement. Furthermore, the average cost of health care per Medicaid recipient is about the same as that of roughly comparable age groups not in the program (Rogers, Blendon, and Moloney, 1982). The program does not appear to be less efficient than the private system, occasional incidents of fraud and abuse notwithstanding.

These groups in particular have benefitted substantially from Medicaid coverage: the elderly poor, mentally retarded, physically disabled and blind, and children in low-income, single-parent families. Unfortunately, as Joe, Meltzer, and Yu (1985) so vividly illustrate in their recent paper on Medicaid, eligibility for the program varies considerably and seemingly capriciously from State to State, and there are arbitrary, illogical exclusions even within States.

Overall, in 1985, the Medicaid program covered less than one-half of the families defined as poor and near poor (near poor is defined as an income of $12,722 or less for a family of four). Although some of these families may be covered by employer-paid health insurance, between 25 and 35 million people in this country are without any health insurance coverage. This lack of insurance coverage is not confined strictly to the poor, but it is concentrated within the lower-income strata.

During the 1970's, uninsured poor individuals requiring acute care could usually obtain it, because the cost of that care could be shifted to paying patients. As the Nation moves from passive, retrospective, full-cost reimbursement of hospitals to cost-conscious, price-competitive purchasing of care, these hidden cross-subsidies will be squeezed out of the system like water out of a sponge. The major challenge facing the actual and originally intended beneficiaries of the Medicaid program will be to weather that transition until, at long last, the Nation sees fit to put into place a more coherent, comprehensive program covering all of the Nation's low-income families.

Impact on health care providers

In their original design, the Medicare and Medicaid programs were conceived of essentially as adaptations to a larger, private health care market. That was one of the key decisions shaping the development of these programs. A second key decision was acceptance of the principle that patients covered by the programs must have free choice among providers. That principle made it virtually impossible for the Government to act as a "prudent purchaser," that is, to seek low prices by playing off one provider against the other. From the perspective of providers, these two decisions fashioned a supplier's dream world.

Practically, the first decision meant that institutions were to be reimbursed on a retrospective, full-cost basis, with only minor constraints on the definition of costs, and that for-profit institutions were to be granted a guaranteed rate of return on the proportion of their equity allocable to Medicare patients. Under the Medicare programs, physicians were to be paid their "customary" fees, if the latter were judged "reasonable" within the pattern of fees "prevailing" in the physicians' market area. Because the specific design of the Medicaid program was left to the States, the Medicare reimbursement formulas could not be imposed upon that program, although many States adopted these methods for their Medicaid programs as well.

It is tempting, in retrospect, to criticize the architects of the two programs for these crucial design parameters, but that would be unfair. First, within the politics of the mid-1960's, these parameters were the price for acceptance of the programs by health care providers. Second, it may not have been foreseen at the time just how dominant the two programs would become in the financing of American health care.

Unfortunately, the "market" to which the two programs sought to adapt themselves was one dominated by a private insurance industry that was itself too splintered to confront the providers of health care with effective countervailing market power, short of violating the antitrust laws. By adapting themselves to this context, the Medicare and Medicaid programs became, for the most part, just one more structurally impotent payer in the health care market.

The principle of "divide and conquer" operating in the market for health services during the past two decades has bestowed truly generous cash flows upon the providers of health care. If the American health care sector today is truly the world's best, as is so often claimed, the credit goes not only to the Nation's well-trained physicians, but also to the taxpayers and patients who have financed for these professionals abundant physical resources with which to ply their trade. Furthermore, our Nation has shown its gratitude by granting the owners of these resources high monetary rewards per unit of resource (e.g., per physician hour, per band-aid, per pill).

It is widely appreciated that lavishing material comforts on children, while failing to discipline them, can lead to turbulent adjustment problems during adolescence. Unfortunately, what is true of children is also true of entire economic sectors, where munificent rewards and a lack of market discipline can foster much untoward behavior. There is now general agreement that our health care sector has suffered this fate. As the health care market shifts from past reimbursement practices toward cost-conscious, price-competitive, "prudent" purchasing, that sector exhibits all of the symptoms of a spoiled adolescent. There is posturing all around over threats to the "quality of care". There is lamenting over declining incomes. There is pouting aplenty, for example, the threat that the Medicare fee-freeze will lead to "two-tier" health care for the aged, or the practice of 'dumping' patients in response to prospective payments (a practice that gained momentum during 1984, as the hospital industry celebrated its highest profit margins in years!)

The point of the preceding analogy is not to offend. On the contrary, it is intended to remind us that, just as one cannot fairly blame spoiled adolescents for their tantrums, so we should refrain from casting aspersions on the character of our health care providers. By granting them, without so much as an argument, a license to take from our collective insurance treasuries virtually as they pleased, we have educated them to a way of life, and to expectations, from which they can be weaned only gradually, and from which they should be weaned gently and with patience.

Indeed, something more can be said on behalf of our providers. For all we know, certain ethical constraints induced the providers from taking less than they might have. To gain perspective on the issue, one need merely imagine what other actors in our economy would have taken under similar circumstances. Clues can be had by beholding the comportment of our defense industry, and one wonders what investment bankers or the legal profession might have done with such a license.

Now facing the providers of health care is the challenge to adapt to the newly emerging market environment without compromising the ethical standards that lie at the heart of a good health care system. As the choreographers of the system, physicians have a central role to play in this adjustment. The next decade or so will show how faithfully the medical profession will uphold its code of ethics under fiscal siege.

Among the adjustments providers must make in the years ahead is acceptance of the laws of supply and demand. Throughout the past two decades, our providers fought Government regulation with appeals to the putative virtues of a free market. That posture was cheap and easy as long as supply was relatively taut. It is severely tested when there is excess supply. There is now agreement that the Nation has an abundance—if not an outright surplus—of physicians and a glut of acute-care hospital beds. A challenge facing providers is to accommodate to the notion that the purchasers of health care will seek to exploit this surplus to their own economic advantage and that, within a market economy, that form of exploitation is entirely legitimate. Concretely, this will mean that providers must ready themselves to bargain hard with the Government over compensation levels. Alternatively, providers must learn to accept whatever compensation the market permits the Government to impose upon them. Third-party payers, be they private or public, would be derelict in their fiduciary roles if they failed to exploit their new-found market power. It is too late to decry such efforts as "unfair."

Impact on the government

In 1965, Americans spent 6.1 percent of their gross national product on health, of which 26 percent was paid with government funds. By 1983, the Nation spent 10.8 percent of its GNP on health, and 42 percent of that total was paid with government funds. In 1965, State and local governments devoted about 8 percent of their budgets to health care; by 1983, that percentage had risen to about 14. The corresponding figures for the Federal Government are 4.5 and 12.5 percent, respectively. The government sector is now the predominant purchaser of health services in this country, and health care represents one of that sector's major outlays. Because every dollar of health care expenditure represents a dollar of health care income for some providers, we may also say that government today is one of the major suppliers of health care incomes in the Nation.

For the most part, the increased role played by the Government in health care reflects the Nation's decision, in the mid 1960's, to have the Government take on responsibility for the health care of the aged and the poor. To the extent that voters participate in such decisions at all, it was their choice. As was noted earlier, however, a part of the increase can be attributed also to the design parameters of the Medicare and Medicaid programs. These parameters literally entrusted providers with keys to the public treasury.

Private payers and the providers of health care have lamented for years that the Government has not picked up its fair share of the national health care bill, by refusing to pay for bad debts, charity care, and other exclusions from allowable costs, Government has effectively shifted costs to the private sector. One could, however, construct an alternative scenario. Over the 2-year period 1980-82, for example, real (inflation-adjusted) total national health expenditures grew by 12.7 percent. Total real outlays under the Medicare program, on the other hand, grew by 27.9 percent. Medicare outlays on physician services grew even faster, by 30.9 percent (Freeland and Schendler, 1984). It would be difficult to argue that these figures resulted from a growth in the number of the aged or changes in their morbidity. Therefore, the thought occurs that providers found it relatively easier in those 2 years to cull added health care incomes from the public sector than from the private sector—that we were witnessing cost-shifting in reverse.

The apparent ability of providers to effect such shifts raises the question of how Government, hard pressed by voters to control its budgets, might control its outlays on health care. One approach, taken virtually everywhere else in the industrialized world, would be to control overall national health care expenditures along with the Government's share of that total. That approach is taken by other societies to discourage the emergence of two-tier health care systems. Unfortunately, nonarbitrary criteria do not exist for setting the overall percentage of the Nation's GNP that should go to health care. Furthermore, it is virtually impossible to enforce whatever limit is chosen in the absence of a full-fledged national health insurance system.

For reasons already indicated, Government control over the entire health care sector is out of the question in the United States. On the other hand, the Government can no longer afford the pretense that Medicare and Medicaid programs are mere appendages of the American health care market. In many areas these programs dominate that market. It was therefore inevitable that the two programs would eventually go their own way. Prospective compensation of hospitals by diagnosis-related groups is the first step in that direction. Fee schedules of some sort for physicians is apt to be the second step. As already mentioned, unless health care providers quickly learn to negotiate such compensation levels with the Government, a further logical step will be competitively bid compensation levels, effected either through health maintenance organizations or preferred provider organizations. Although a march in this direction will surely elicit from providers cries of "two-tier" health care, it is hard to think of an alternative approach to budgetary control at this time. In a real sense, it is the approach providers asked for during the health policy debates of the 1970's.

A case can be made that control over public health budgets is far from compelling in the first place, because the United States has one of the smallest public sectors in the industrialized world (Japan being the sole exception). Most other industrialized nations spend between 40 and 50 percent of their GNP on the public sector, but the comparable American figure lies between only 33 and 35 percent. Such an argument, however, carries little political weight at this time. For better or for worse, American voters, both young and old, rich and poor, now wish to see their public sector severely constrained. And, as already noted, there are other priorities with legitimate claims on public funds.

There is one challenge American voters might put to health care providers before voting additional allocations for health care. Neighboring Canada currently spends a little more than 8 percent of its GNP on health care. With that allocation, it has freed every Canadian citizen from anxiety over the financial cost of illness and granted every citizen access to a common health care system. By contrast, the United States is already spending close to 11 percent of its GNP on health care without, however, guaranteeing every American citizen freedom from worry over health care bills and financial access to health care. An allocation of 11 percent of the GNP is not skimpy; it represents a generous supply of health care incomes. The challenge faced by American health care providers is to convince American voters that, relative to the quality of Canadian health care, the quality of American health care is sufficiently superior to warrant an extra 3 percentage points or so of the GNP (and even more) along with the financial distress still suffered by many American patients. It is an interesting challenge, worthy of careful research.

Implications for the future

Throughout the industrialized world, nations are wrestling with the economic implications of an aging population. Many of the European nations already have attained today the top-heavy population pyramid the United States will attain in the early part of the next century. Japan's population pyramid, too, is now rapidly shifting towards the European pattern. These demographic shifts will create intergenerational tension everywhere. The United States by no means stands alone in this struggle.

Every nation, too, has its group of economically disenfranchised citizens who cannot afford to pay fully for what are considered to be the basic necessities of life. How a nation copes with the economic problem presented by its aged and its poor depends only weakly on its overall economic strength. Much more decisive is the amorphous something called a "shared social ethic." Nations differ quite substantially in terms of their dominant social ethic and, also, in the degree to which that dominant ethic is actually shared.

To illustrate, consider the following concise statement by the Government of Canada (1983) on the social ethic governing the distribution of health care in that country:

> "The Government of Canada believes that a civilized and wealthy nation, such as [Canada], should not make the sick bear the financial burden of health care. Everyone benefits from the security and peace of mind that comes with having prepaid insurance. The misfortune of illness, which at some time touches each of us, is burden enough: the cost of care should be borne by society as a whole."

Whatever reaction to this statement one's own ideology may trigger, the statement is a crisp definition of a social ethic, and one that seems widely shared by Canadians of all political stripes. Consistent with that definition, Canada maintains a universal health insurance system financed not through actuarially sound insurance premiums, but through a tax system based on ability to pay.

Most of the European systems have adopted a similar approach. To be sure, all of these nations agonize over the enormous expense of their systems, which absorb anywhere from 6 to 10 percent of their gross national product. But the public debate over health policy in these countries does not take place through special conferences on "financing health care for the aged," or "financing indigent care." These problems have been completely folded into the problem of one health insurance and health care system imposed on virtually all economic strata of society.[2]

The imposition of one highly regulated health care system upon all members of society inevitably carries with it certain hidden costs, among them loss of the innovative drive of looser systems such as ours, not to mention the frustration that providers suffer over their loss of certain freedoms. Be that as it may, this symposium is not the proper forum to criticize foreign systems nor to advocate them. The reason for describing them briefly here is simply to make an important point, namely, that in terms of strategy and tactics the lessons from health systems in other countries are rather meager, because their approaches are based upon a social ethic that we do not seem to share.

As argued elsewhere (Reinhardt, 1985), it would be difficult for an American to describe to foreigners the social ethic driving American health care, even if an entire page were set aside for that purpose. To be sure, many Americans hold crisp and fully coherent views of their own on this matter. The problem is that these views vary widely among individuals; there does not seem to be a lasting set of ethical precepts that are widely shared. We lack an accepted blueprint on ethics against which to assess alternative strategies for the Medicare and Medicaid programs. Without such a consensus, it is nearly impossible for a policy analyst to render expert advice on the issue without incorporating his or her own ideological predisposition.[3] Rather than proffering such advice, it may therefore be more productive to raise the following fundamental questions:

- Is health care to be viewed primarily as a basic, private consumption good (such as food, clothes, and shelter), or should one view it as primarily a public good, a community service (such as elementary and secondary education)?
- Is access to at least a basic set of health services the right (that is, a basic entitlement) of every American citizen, or is there merely the presumption of a moral obligation on the part of providers to facilitate access to basic health services?
- Even if access to basic health care was deemed a right, should the definition of that right, and responsibility for enforcing it, be the prerogative of State and local governments, or is that the proper responsibility of the Federal Government—that is, should there be nationally defined and nationally enforced standards?

Anyone who has followed our debate on national health policy during the past 20 years must conclude that no clear answers to these questions have emerged. And yet, these fundamental questions lie at the heart of the broader question on what direction the Nation should take with regard to the Medicare and Medicaid programs.

Consider, for example, the first question. To hold that health care is essentially a basic, private consumption good implies that the financing of health care is primarily the responsibility of the individual recipient of that care, although society may well see fit to assist poor individuals financially to gain access to at least a basic set of health services. Our society adopts that view in connection with certain essential commodities, such as food, shelter, and clothing. In the literature, that view is sometimes referred to as the "basic-needs" approach.

The basic-needs approach clearly countenances a two- or multiple-tier health care system, just as we countenance it for food, shelter, and clothing, and even for higher education and jurisprudence, if not de jure, then at least de facto. On that perception of health care, the Medicare program must be judged ill-conceived from the start, for it offers too much to the upper income strata and perhaps not enough to the poorest among the aged. For example, adherents to the basic-needs approach would not deem it essential to offer Medicare beneficiaries complete freedom of choice among providers. Furthermore, it would be deemed quite acceptable to permit well-to-do aged complete freedom of choice (financed, of course, with their own resources), a privilege not made available to their poorer peers.

Under the basic needs approach, it would make sense eventually to fold the Medicare program into governmentally encouraged (or even mandated) life-cycle planning on the part of individuals. Individuals could be encouraged through the tax code (or mandated) to contribute during their worklife stipulated minimum annual payments into individually owned accounts established specifically to finance health and long-term care during retirement. The accounts could be held in the private sector, albeit under public supervision. The Medicare program itself would then convert to essentially a means-tested welfare program, making transfers to individuals only if the funds accumulated during their worklife proved inadequate. Clearly, such an approach would represent a sharp departure from the social ethics originally packaged into the Medicare program, but it would be fully consistent with a basic-needs approach to health care.

Readers may be surprised to see the second question raised at all. It may be thought that this issue had been settled long ago when this Nation subscribed to the much-mouthed political slogan that "health care is a basic right." The mouthing of slogans, however, do not make a "right." Legislating it might. If one surveys the practice of health care in our realm, and even the literature on the subject (Blumstein, 1984), one must conclude that the second question is still a relevant issue.

---

[2] In every one of these nations, there is a small private sector that serves as an escape valve for patients to pay for speedier treatments or treatments as private patients. Usually, much less than 10 percent of the population is privately insured, even in the United Kingdom.

[3] As an immigrant from, first, West Germany and then Canada, and as an erstwhile pauper, I am favorably disposed towards national health insurance systems that offer middle- to low-income families a dignified and anxiety-free health care experience. As a long-time student of the American health care sector, however, I have come to doubt that national health insurance is compatible with the American ethos and, especially, with the political process in this country. For the poor in this country, the most humane, politically feasible system would probably be a multi-track system with a bottom tier served primarily by health maintenance organizations.

Consider, finally, the third question that can be rephrased as follows: Should residents in State X be at all concerned over the economic and physical welfare of fellow Americans in State Y, or is that none of their business?

If the answer is, "Yes, residents of State X should be concerned with the welfare of fellow Americans in State Y, and not only when the latter are trapped somewhere abroad," then it would follow that there should be national standards for basic health care; the definition of a basic right to health care and the responsibility for enforcing that right cannot be left fully to the devices of individual States. If that be the dominant social ethic on this point, then the Medicaid program must be judged as ill-conceived and poorly executed.

On the other hand, if the dominant social ethic dictates the answer, "No, the health care experience of residents in State Y is not the business of residents in State X," then the Medicaid program in its present guise makes perfect sense, but the Medicare program becomes suspect. After all, it would reflect a contorted social ethic to state that we should practice nationhood in health care only with respect to people 65 years of age and over, but not with respect to children or middle-aged fellow Americans.

To speculate on the future course of Medicare and Medicaid is to speculate on the dominant answers to the three fundamental questions raised above. If bets had to be made on these answers at this time, it would seem reasonable to place one's marbles as follows:

- Health care is essentially a basic, private consumption good, and we shall countenance two- or multi-tier health care.
- Access to basic health care is not an entitlement, but merely a moral obligation imposed on providers and financed, indirectly, by various formal or informal cross-subsidies.
- The provision of access to health care is a State and local, not a Federal, matter.

Whether the Medicare program can ultimately be made consistent with these tenets—they imply, at the least, the conversion of Medicare into a means-tested program—remains to be seen. Indeed, in the end these tenets may not win out after all. Occasionally, even economists have been wrong in their predictions.

References

Blumstein, J. F.: Providing Hospital Care to Indigent Patients, Hill-Burton, A Case Study and a Paradigm. Paper presented at the Vanderbilt University Conference on Uncompensated Care, Defining Rights and Assigning Responsibilities. Nashville, Tenn. Apr. 6-7, 1984.

Council of Economic Advisors: Economic status of the elderly. *Annual Report of the Council of Economic Advisors*. Washington, D.C., Feb. 1985.

Davis, K., and Rowland, D.: Medicare financing reform, A New Medicare premium. *Milbank Memorial Fund Quarterly* 62(2):300-316, Spring 1984.

Freeland, M. S., and Schendler, C.: Health spending in the 1980's, Integration of clinical practice with management. *Health Care Financing Review*. Vol. 5, No. 3. HCFA Pub. No. 03169. Office of Research, Demonstrations, and Statistics, Health Care Financing Administration. Washington. U.S. Government Printing Office, Spring 1984.

Fuchs, V. R.: Though much is taken, Reflections on aging, health, and medical care. *Milbank Memorial Fund Quarterly* 62(2):143-166, Spring 1984.

Joe, T. C. W., Meltzer, J., and Yu, P.: Arbitrary access to care, The case for reforming Medicaid. *Health Affairs* 4(1):59-74, Spring 1985.

Meyer, J. A.: Comment on Medicare financing reform, A new Medicare premium. *Milbank Memorial Fund Quarterly* 62(2):317-324, Spring 1984.

Reinhardt, U. E.: Hard choices in health care, A matter of ethics. *Health Care, How to Improve It and How to Pay For It*. Washington. Center for National Policy, Apr. 1985.

Robert Wood Johnson Foundation: *Updated Report on Access to Health Care for the American People*. Special Report No. 1. Princeton, N.J., 1983.

Rogers, D. E., and Aiken, L. H.: Preserving Medicare Care Gains for Older Americans. Testimony before the House Select Committee on Aging, United States Congress, Jan. 26, 1984.

Rogers, D. E., Blendon, R. J., and Moloney, T. W.: Who needs Medicaid? *N Engl J Med* 307(1):13-18, 1981.

Wall Street Journal: Hospitals in cost squeeze "dump" more patients who can't pay bills, p.33. March 8, 1985.

blank page

Congressman Dan Rostenkowski

Congressman Dan Rostenkowski is the Chairman of the House Committee on Ways and Means and Joint Committee on Taxation; he is also a member of the Democratic Steering and Policy Committee. He has been a member of Congress since 1958 as the representative from the Eighth District of Illinois. Prior to his election to Congress, he was both a State representative and a State senator. He was educated at St. Johns Military Academy and Loyola University, and served 2 years in the infantry in Korea.

Impact on beneficiaries

Since the Committee on Ways and Means has jurisdiction in the health area over Medicare and not Medicaid, I will primarily focus my comments on the impact of the Medicare program on our health system and on our Nation's elderly and disabled beneficiaries.

The primary goals of Medicare were to prevent acute illness from spelling financial disaster for the elderly and disabled and to generally increase the availability of medical services to Medicare beneficiaries. Prior to Medicare, a hospital stay could mean financial ruin. Today, this is generally no longer true. Formerly, the elderly and disabled had immense difficulty buying health insurance. To many, it simply was not available; even if health insurance was theoretically available on the market, it tended to be priced out of reach or riddled with preexisting-condition provisions and exclusions.

Today, Medicare offers a considerable amount of protection against the costs of acute-care hospitalizations. The significant expenditures under the Medicare program indicate that there has been increased access to medical resources for the elderly and disabled. In fiscal year 1986, Medicare program expenditures are projected to be $77.2 billion, largely financed from nonpremium sources of revenue. Yet despite this huge expenditure of public funds, Medicare still covers less than one-half of the total health bill for the elderly. Thus, even though Federal outlays have grown, the elderly continue to expend on personal health care, as a percentage of their real income, as much today as they did prior to the implementation of the Medicare program.

There is, however, no doubt that Medicare has had a favorable health impact on its beneficiaries. One of the strongest, although crude, indicators of the impact of Medicare is what has happened to life expectancy at 65 years of age. During the decade of the 1950's, life expectancy at age 65 increased by less than 5 months. After Medicare, during the decade of the 1970's, life expectancy at age 65 increased by more than 14 months, about three times the increase experienced during the 1950's. Although this may not all be attributable to Medicare, I am sure that Medicare has played a major role.

Furthermore, a statistical measure cannot indicate the peace of mind that many have felt from knowing that a major portion of their hospital and doctor bills would be paid. It does not indicate the relief children of aged parents feel when they no longer have to shoulder the financial burdens of their parents' acute-care medical bills. It does not indicate the extent to which Medicare has fostered the development of medical technology that has served to reduce pain, suffering, and morbidity.

Medicare, along with social security, has contributed to the overall financial soundness of the aged. When Medicare was enacted, 28.5 percent of the aged were living in poverty, compared with 14.7 percent of the entire population. In 1984, the poverty rate for the elderly was 12.4 percent; for the general population it was 14.4 percent. From 1970 to 1983, mean real income increased by 19 percent per capita for the elderly and by 10.5 percent of the non-elderly. Recent data show that the mean per capita income of the elderly now exceeds that of the non-elderly; this was not true when the program began. Although many of the elderly still live at or near poverty, our system of social insurance (of which Medicare is a part) has contributed greatly to the general economic well-being of the elderly. Medicare guards all beneficiaries from financial ruin resulting from an expensive hospital stay.

I do not mean to paint too rosey a picture; there are many challenges that remain. One is the significant increases in out-of-pocket expenses faced by the elderly. This is painfully illustrated by the dramatic increase in the Part A deductible that beneficiaries will be facing in 1986. The Part A deductible will increase from $400 in calendar year 1985 to $492 in calendar year 1986, an increase in excess of 23 percent. Out-of-pocket expenses are increasing, not only under Part A but also Part B of the program, especially when you take into consideration amounts charged by physicians who do not accept Medicare assignment. Despite the economic well-being of many of our elderly, these out-of-pocket expenses can be financially devastating to them.

Serious thought must also be given to the increasing need and demand for long-term care for the elderly. Individuals over 75 years of age currently constitute 4.5 percent of our population; by 2025, they will constitute 8.4 percent of the population. Increasing life expectancy and other demographic change will mean more attention must be given to the long-term and chronic care needs of the elderly. The significant budget constraints that appear likely to be with us for the immediate, if not foreseeable, future, mean that addressing their needs will be a real challenge for us all.

Impact on health care providers

Medicare has had a tremendous impact on the delivery of health care in the United States, from improving the hospital capital plant to serving as a prime mover in desegregating many hospitals in the mid-1960's.

National health care expenditures have increased form 6.1 percent of the gross national product to nearly 11 percent in 1985. This growth in the health care industry was partially fueled by Medicare and Medicaid; spending by Medicare alone accounts for approximately 30 percent of all short-term hospital revenues. By providing Federal dollars, Medicare and Medicaid have greatly expanded the availability of health services which, in turn, have fostered the development of new medical devices, procedures, and technologies.

It is also clear that Medicare's payment rules and regulations have influenced the practice of medicine. Many argue that cost-based reimbursement for hospitals and charge-based reimbursement for physicians, which governed the system for most of its 20-year history, has contributed to an over-expansion of health care resources and to longer lengths of stays in hospitals. It is widely believed that if most of the cost of services is reimbursed by third parties (Medicare, private insurance), neither the provider nor the patient has significant financial motivation to control utilization. Given that medicine is both an art and a science, there is always pressure, for which there may not be a countervailing force, to order an extra test, take an additional X-ray, or stay in the hospital another day.

This rapid increase in program costs, especially in the late 1970's and early 1980's, led to pressure to enact mandatory hospital cost-containment controls. After several years of debate, mandatory cost-containment legislation was defeated. A voluntary cost-containment program was organized within the health care industry. The failure of the voluntary effort and the double-digit health care inflation that ensued led to the passage of the prospective payment system for hospital payments.

The recently enacted hospital prospective payment system (PPS), a price-based system of payment, represents a radical change, and reverses some of the incentives of the old system. For example, under the prior system, the economic incentives encouraged providers to keep a patient hospitalized for a longer period of time. Under the new system, a hospital is encouraged to reduce the length of stay. Although the downward trend in average hospital length of stay has gone on for several years, it is amazing that over the last 2 years the average hospital length of stay for a Medicare patient has fallen from 9.4 days to 7.7 days.

PPS has created a whole new set of concerns and problems. Under the prior system, many were concerned that too much money was being spent on new technology. Every hospital wanted, and in many cases bought, the most up-to-date equipment. Today's PPS approach has now led many experts to be concerned about the opposite situation arising, that the new financial incentives may lead to an underinvestment in new technology. The Prospective Payment Commission was created, in part, to review issues such as these and to recommend changes that may be needed to counteract inappropriate disincentives for investment in new technology.

Quality of care has always been a high priority in the program. Under the old system, there were few concerns that care would be compromised because of financial incentives. However, under PPS, hospitals have economic incentives to release patients as quickly as possible. I am beginning to see studies and newspaper reports, as well as receive direct complaints, that patients are being pushed out of the hospital door too quickly. Besides controlling admissions, it is hoped that the Peer Review Organizations will take on the important role of ensuring the quality of care, including protecting beneficiaries from early discharges. I know that Congress will exercise its oversight responsibilities diligently in this area and, if necessary, take appropriate action to remedy any problems that may be identified.

Impact on government

In crafting the original Medicare program, there were several key policy decisions made during the initial program design. The most important ones were that Medicare would be: a social insurance system covering all elderly rather than a means-tested program limited to the poor; a program primarily financed by earmarked revenues; a cost-based reimbursement system; and a program providing coverage primarily for acute espisodes of illness.

Each of these decisions has had some impact on Medicare expenditures and on the ability of the program to meet its goals of providing high-quality health care for our Nation's elderly. I believe the principle of universal coverage in a social insurance system should not be altered. All individuals should participate in the system, and it should not become a means-tested program. In the future, however, it might be appropriate to change some aspects of the program, taking into account the income of beneficiaries. For instance, scaling premiums to income does not alter the basic characteristic of a social insurance system that provides benefits alike to both the rich and poor.

Another important policy that should be maintained as Medicare evolves is that the program continue to be financed by earmarked revenues, primarily payroll taxes, thus insuring that the balance between benefits and revenues continue. The fact that both workers and employers contribute has insured the program's sensitivity to the taxpayer. This joint contribution supports the premise that retirement and health benefits are an earned right. The pride of participating in a fair and universal social insurance system should not be underestimated.

Modeling the financing of the hospital insurance portion of the program after the old-age and survivors insurance program allowed the current cohort of retirees, many of whom lacked health insurance and who could not afford or qualify for private health insurance because of health reasons, to be eligible for benefits. These benefits were financed by workers. These workers, in turn, were promised health benefits when they reached age 65 or became disabled. This is a social contract that must and will be honored in the future.

As a part of the task of assuring the long-term solvency of the hospital insurance trust fund, some changes must be made in financing over the next few years. State and local government employees should be brought into the Medicare program just as Federal workers were in 1983. Perhaps certain excise taxes should be increased and dedicated to the disability or hospital insurance funds. Given the improved financial health of the elderly generally, perhaps a larger share of revenues for Medicare should come from them. However, the principle of earmarking taxes should continue.

The cost-based reimbursement system was thought necessary to secure provider support for the program, thus ensuring enactment of the program. Cost-based reimbursement served the program well and helped to assure the broadest participation of health providers in the Medicare program. However, as program costs have escalated (many believe in large part because of cost reimbursement), the emphasis for public policymakers in the Medicare area over the last few years has been on cost control and reimbursement reform.

A final key issue relates to what is covered by Medicare. The primary concern in 1965 was with the problems that hospital costs presented for the elderly. That concern is reflected in the benefit structure which emphasizes hospital coverage. Over time, policymakers have turned their attention to other areas of health need. For example, the Medicare hospice benefit was added in 1982, payment was allowed for services provided in ambulatory surgery centers, and so on.

This "evolution" of Medicare will continue over time. I have already stated concerns about the elderly's increasing out-of-pocket expenses and their chronic care needs. Exactly how these needs should be met is not clear to me, but which expenses are to be covered by Medicare is not carved in granite.

Implications for the future

Several years ago, experts were predicting that by 1995 the Medicare hospital insurance (HI) trust fund would need at least $500 billion of reduced outlays and/or increased revenues to remain solvent. Now, actuaries predict that, largely as a result of cost-containment efforts, enough has been achieved to provide for sound financing beyond 1995. The Board of Trustees' 1985 report on the status of the health insurance trust fund projects that the HI trust fund will be exhausted sometime between 1998 and the year 2000 using intermediate economic assumptions. In order to maintain actuarial balance, additional financing and probably expenditure control will be needed.

The health system has changed dramatically over the last few years. Given the changing nature of medical care, advances in medical technology, the aging of America, the dramatic changes in the delivery of medical care, and changes in the medical problems faced by the elderly, Medicare will need to continue to evolve during the next 20 years to meet these changing needs.

Medicare is not at a major financing crossroads. The new prospective payment system (PPS) has only recently been enacted. The initial indications are that this change has reduced resource use in hospitals without significantly affecting quality of care. However, the jury is still out on the long-run success of these changes and on the impact they will have on quality and access to care.

There will be a continual need to monitor the quality of care as providers are forced to become more cost conscious. As the initial PPS legislation provided, it is anticipated that the diagnosis-related group (DRG) system will be fine-tuned. There will be periodic adjustments in the relative prices paid for the different procedures. Better adjustments for severity of illness are needed. As a result of the new system, some hospitals will receive large reductions in their Medicare revenues, not necessarily because they are inefficient. My personal view is that the new system should have been phased in over a longer time period, to allow time for correction of imperfections in the construction of the PPS system.

Economists have long argued that expenditures are equal to price times quantity. Regulating the price without volume controls may not bring about the desired result of reducing total expenditures. At the moment, there is no explicit control on the volume of services except that provided by Peer Review Organizations (PRO's) and, to a lesser extent, Medicare intermediaries. The number of admissions is a major indication of the volume of hospital services. Most economists were wrong in predicting that admissions would increase under PPS. Instead, admissions have declined. However, this may be only a short-run phenomenon reflecting changing conditions in the health care delivery system generally. Again, we should be ready, if necessary, to make changes if, for example, hospitals respond to the economic incentives by increasing admissions that may not be warranted.

As the prospective payment system matures, we as a society will need to rethink how we reimburse providers for educational costs, as well as develop adjustments for severity of illness and for hospitals that serve a disproportionate share of low-income beneficiaries. We need to revise the method of payment for capital costs. PPS raises concerns about the cost of medical education, new technology, and care for the poor, and forces explicit decisions about who will bear these costs. The benign cross-subsidy arrangements of the past are breaking down under the DRG approach and the more rigorous "prudent purchasing policies" of the private sector. Government (or society in general) will soon need to confront these issues. Many members of Congress on a bi-partisan basis understand the implications of the new system and are ready to address these concerns. Some of these issues are currently being considered by the House and Senate in legislation pending before both Houses.

Physician reimbursement will require serious attention over the next few years. Many argue that the fees for some procedures are inflated. They argue that the current system rewards doctors who do procedures and tests, compared with doctors who utilize cognitive or other skills to a greater extent. Adopting a single new universal mechanism for changing reimbursement to physicians may not be feasible or viable. Although it may be appropriate to extend the DRG system to include physician fees for surgical cases, services provided by doctors when treating hospital-based medical cases vary widely, and extension of the DRG payment system to those cases may not be as equitable. How to change compensation to physicians for office-based care is also difficult.

In many ways, changing the way Medicare pays for physician services will be a more complex and politically difficult task than reforming hospital payments. Just one issue is the fact that we are dealing with 400,000 sometimes very independent physicians, compared with 7,000 hospitals, and that we are dealing with 7,500 physician procedure codes, compared with 468 diagnosis-related groups for the hospitals. Another issue is how to assure continued financial protection for Medicare beneficiaries under reformed physician reimbursement arrangements. Under the hospital payment system, hospitals are required to accept the Medicare payment as payment in full. Physicians, on the other hand, have not been required to accept the Medicare payment as payment in full, and are allowed to bill Medicare beneficiaries in excess of the Medicare allowable charge. A precondition for continued beneficiary protection seems to be adequate and equitable physician payment levels and arrangements. This is a delicate issue that challenges Congress and the Executive Branch.

The evolution of the Medicare program will reflect the changing health needs of the elderly. The addition of the hospice benefit is one example of how Medicare has evolved to meet a need. Hospice care did not exist in 1965. Today, some 175 institutions are authorized to provide hospice care under the Medicare program.

For several reasons, the distinction between Part A and Part B services may no longer be necessary. Historically, Part A covered hospital bills and Part B covered physician bills. The variety of new practice settings, including surgicenters and other ambulatory treatment centers, has blurred the distinction. The desire to limit out-of-pocket expenses and provide fair competition between different modes of delivering quality care dictates that the distinction be reconsidered.

We should consider what Medicare can learn from the experience of employer health plans in the private sector. Just as many employees are provided choice among plans, some argue that Medicare beneficiaries could be provided similar choices among alternative plans. Medicare has taken the first tentative step in this direction in providing, as an option, enrollment in Medicare certified health maintenance organizations (or competitive medical plans). There is a significant amount of resistance to going beyond this first step until experience is gained.

Nonetheless, some have argued that Medicare beneficiaries should be provided with a "voucher" and that the beneficiary could then choose which plan to enroll in. Under this scenario, Medicare beneficiaries could choose between the standard Medicare cost-sharing package; more comprehensive plans that provide catastrophic protection, less cost sharing, and an expanded scope of benefits; and preferred provider plans that enlist physicians who are willing to accept assignments and/or "manage" or control utilization. There are many concerns with this type of choice. The so-called "Medigap" insurance market has taught us some lessons about how difficult it is for Medicare beneficiaries to make choices between many different health plans. Difficulty in choosing wisely in not limited to the elderly, I might add. Large numbers of Federal employees (who have a wide range of plans from which to choose) have tended to enroll in the most expensive "high-option" plans, even when their age and health status make this choice unnecessary and imprudent.

What confronts us in the future is how to continue to provide high quality care to beneficiaries in an era of significant budget restraint. This will mean that there will have to be a high degree of communication and cooperation between Medicare beneficiaries, providers, and the Government. Working together, I believe that we can continue to provide good quality health care to our Nation's elderly.

To conclude, let me make it plain that I consider the Medicare program an overwhelming success. I am proud to have participated in its original enactment and in the improvements we have been able to achieve through changes in the law over the years.

Some of Medicare's current problems are by-products of its success. High costs, for example, are partly a reflection of the improved access to better care that Medicare has brought to the Nation's elderly and disabled. We can, so to speak, feel good that these are the kinds of problems we need to solve.

There is no question about the commitment of Congress, and the American people, to the preservation, continuation, and improvement of this popular and important program. For my part, I look forward to playing a role in assuring the program's continued success.

James H. Sammons, M.D.

James H. Sammons, M.D., is Executive Vice-President of the American Medical Association (AMA). Before assuming his present office in 1974, he was in private practice and held various medical society leadership positions at the county, State, and regional levels. He received his medical degree from St. Louis University School of Medicine. He is a member of the National Academy of Sciences' Institute of Medicine, the U.S. Chamber of Commerce Board of Directors, and the National Conference on Medical Planning.

Impact on beneficiaries

Without question, Medicare and Medicaid have expanded access to high quality medical and health services for millions of elderly and financially disadvantaged Americans, a social and medical milestone. Together with private insurance and public financing mechanisms, the vast majority of Americans have been provided with access to the finest medical and health services system in the world. However, weaknesses in the Medicare and Medicaid programs can be found in a number of problem areas, some of which were evident and some of which were not evident when the programs were enacted.

The total cost of providing Medicare services to all eligible recipients, regardless of income, was underestimated. During the 1970's, constraints in the general economy also created constraints in government budgets. Although the number of workers per beneficiary supporting the social security program, including the Medicare trust fund, has decreased, the number of eligible recipients has increased; this disparity will widen further with the progressive "greying" of the population.

Consider the realities. Patients over the age of 65 are the largest users of hospital services, accounting for almost 40 percent of inpatient days. About 5 percent of the elderly occupy 90 percent of the beds in more than 2,100 nursing homes nationwide. Almost 15 percent of aged households live below the official poverty line. By all estimates, problems associated with funding care for older Americans will grow as the demographics change. Over the next 40 years, while the total population grows by 40 percent, the number of Americans over age 65 will double, and the number over age 85 will more than triple. The Medicare financing implications are sobering, to say the least.

Medicaid has helped many low-income Americans secure access to medical and health services despite uneven eligibility, regulations, benefits, and funding from State to State. The irony is that in many, if not most States, inadequate Medicaid funding, coupled with the prospective pricing of Medicare services, is posing a serious threat to teaching hospitals, many of which are located in the inner city and have traditionally served a disproportionate number of needy patients. The problem is compounded by reduced differential payments to teaching hospitals, which incur overhead expenses of about 33 percent because of the greater intensity of services they provide. The American Hospital Association reports that hospitals in general provided $2.1 billion in charity care in 1982, and incurred bad debts of $4.7 billion.

The goals of Medicare and Medicaid have been to assure the target populations' access to mainstream medicine along with the rest of the Nation. It was expected that a continuum of care would be provided, extending from the doctor's office to the clinic or hospital to the nursing home. But persistent financing problems have made these goals elusive. Under both Medicare and Medicaid, there is a movement towards restricting or rationing care through prospective pricing, with some risk of a return to "two-tiered" care. Stringent controls over hospital utilization, through Peer Review Organizations or PRO's, could and probably have accelerated this trend. There have been some reports of and concern about patients being prematurely discharged.

Also, because funding of some Medicaid and Medicare services have fallen short of promised levels, recipients are paying progressively more out-of-pocket costs. One wonders at the wisdom or justice of having Medicare patients at, near, or under the poverty line, in effect, "subsidizing" care for wealthier Americans.

In any case, future challenges facing beneficiaries will evolve from changes within the financing and delivery systems themselves. The use of vouchers as a financing alternative, for example, means recipients would have to learn to "shop" the delivery system to buy access to the kind and amount of services they need. Beneficiaries also will have less freedom of choice if the trends toward restricted or directed access to care continue. Another challenge that is bound to grow is how do we provide adequate funding for nursing home care, especially as the number of Americans over 75 and 85 years of age increases, heating up demands for care. The need for more catastrophic care coverage is likely to pose a parallel challenge.

In short, Medicare and Medicaid beneficiaries have to persuade Federal and State governments to adequately fund their access to mainstream medicine as originally promised, at least to the extent that beneficiaries receive the care they really need.

Impact on health providers

Design of the Medicare program differs markedly from that of Medicaid, so the impact on providers differs accordingly. At its inception, Medicare, with the Federal Government as insurer, was meant to minimally disrupt existing mechanisms for payment, administration of claims, and provision of services. State governments are not insurers under Medicaid, but make direct payments to providers.

Medicaid and Medicare financing, particularly the open-ended nature of the latter, along with first-dollar financing by the private insurance industry and other financing sources, have had a revolutionary impact on health care providers and institutions. In the 1960's, buoyed by a strong economy, the Great Society programs were enacted, including government health care financing programs. Public and private funds were used to expand insurance coverage, train more physicians and other health professionals, build or enlarge community hospitals, and equip them with state-of-the-art technology and resources. The United States created the finest medical and health services system in the world, in terms of quality, and then made it available to most Americans.

Physicians were now being paid for some services they previously provided at little or no cost; hospitals were paid on a cost-plus basis. And total cost was not perceived as a problem until the economic downturn of the 1970's, when the Great Society programs dwindled and some disappeared. The high cost of medical and health services suddenly became a national concern, with physicians, as purchasing agents for patients, and hospitals, as the most expensive locations for care, subject to considerable criticism. The truth is, however, that we the people—all of the people—wanted, even demanded, a system that provided the best kind of care. So we financed and built one.

Now, because of the current gap between virtually unlimited health care wants and needs and limited national resources, providers, along with other private and public entities and individuals, will have to deliver care as efficiently and cost effectively as possible while meeting real patient needs. This is a problem that also confronts other industrialized nations. Considerable progress already has been made in moderating annual health care cost inflation. Meanwhile, this Nation will have to determine how much of its financial resources it will devote to the health of its people, including those who are medically needy—especially those with limited financial resources of their own.

We must recognize that modern medicine *is* expensive; the challenge is to operate in a cost-effective way and yet maintain the quality of medical and health services and the real needs of patients. This will require the concern, commitment, and cooperation of everyone involved.

Impact on government

As the disproportionate growth of the elderly segment of the population continues, government health care financing problems are bound to intensify. Current financing methods already are in question to some extent. Can a comparatively smaller, younger generation continue to pay the health care bills of the older generation, even the wealthy? Should a means test or something like it be required? Should the tax system be changed to more evenly spread the financing burden among all age groups? Are there alternatives to Medicaid? Are there policies that would encourage people to buy private health insurance from sources other than the workplace? Should changes in the tax laws be used to create a gradual shift toward a new private health insurance structure? The fact that government has no money of its own, only that which it gets from the people, means the people, all of the people, ultimately will have to find answers to such questions. That is the only way to maintain public faith in the "system." And these issues are of great interest to the public. In a recent AMA survey of public opinion on what major issues are facing the Nation, aid to the elderly emerged as our first societal priority.

No matter how Federal or State governments fund and administer Medicare or Medicaid, what is needed, from the Government's point of view, is certainty regarding the total amount of annual expenditures. For example, cost-plus reimbursement under Medicare encouraged cost overruns, so Government didn't know the total cost figure until the end of its fiscal year. At the same time, Government support should be adequate to meet real patient needs. This represents an ongoing dilemma of addressing beneficiary requirements while attempting to control costs.

As enacted, Medicare and Medicaid did encourage flexibility in terms of freedom of choice for patients and providers in seeking and delivering care. More recently, the programs have added elements of competition to the marketplace. But the programs also have become more inflexible through regulatory and budgetary controls over the kind, amount, and locales for care. We must avoid a situation where Government, through its health care financing programs, becomes a kind of catchall or second-hand regulator of the entire medical and health services system. No specific, rational policy has surfaced regarding what share of the gross national product should be devoted to health care for the people, except for critics who say it is already too high. Voters might agree. Patients might disagree. And in fact, AMA surveys have revealed the public does see the cost of health care as a major problem; at the same time, the public believes the Nation is not spending enough for the care of its people. To create a more rational, long-term, overall policy for health, the AMA has brought together the representatives of about 150 private and public organizations involved in or concerned about the financing and delivery of care. As a 3-year project, these representatives are developing a health policy agenda for the American people, to be completed by the end of 1986. This agenda will provide the Nation with a set of health policy principles and plans that the organizations involved can use in health policymaking. Through this project, we hope to give the American people a durable and doable health policy with which to address present and future problems in the financing and delivery of health care.

Implications for the future

It can be said that most western, industrialized nations have reached a crossroads in the financing of health care. Some have given total control to the public sector; others, like our own, use a combination of public and private sector control. Given the social and political philosophies and traditions that prevail in this democracy of ours, I believe the American system will continue to be pluralistic. But the public and private sectors together need to face the difficult issues before us and find answers—some of them soon—to the problems of our day, including those associated with the funding of Medicare and Medicaid.

If we are indeed at a crossroads, some of these roads offer us opportunity as well as concerns. Millions of Americans have now adopted healthier lifestyles. There is evidence to suggest that two of every three Americans have improved their eating habits. Many have stopped smoking. Regular exercise is helping to improve the health status of millions more with sports such as racquetball, tennis, bicycling, jogging, swimming, and other activities. Consumer and business fitness converts bought an estimated $960.3 million worth of gymnastic equipment in 1983, up 33 percent from 1982.

More than 160 medical societies nationwide have joined business and civic groups in creating local health care coalitions to address community health problems, and the focus is not only on those issues related to cost. They are promoting wellness programs, safety in the workplace, and better health habits by employees and local residents. By one recent count, more than 50,000 companies have developed employee fitness programs. Fitness pays big dividends in lower health care costs and absenteeism and higher morale and productivity. One company with an elaborate employee fitness center reported the average health care claim for exercisers was $562, compared with $1,003 for nonexercisers.

The results of such developments, along with improvements in medical science, technology, and techniques, have been gratifying. Average life expectancy is nearing 75 years. Since 1940, deaths from heart disease have dropped by 25 percent and from stroke, by 40 percent. Similar improvements have been made in other disease categories.

Medical device manufacturers are concentrating on technology that makes care more cost effective. Now under development is a $15,000 device that can accurately tell what allergies a patient has through a simple blood test. New devices such as computerized tomographic scanners and nuclear magnetic resonance, that allow physicians to "see" inside the body, have greatly enhanced their ability to make rapid and more accurate diagnoses, obviating the need for more risky—and costly—invasive procedures. In 1950—not that long ago—there was no such thing as a joint replacement, organ transplant, artificial heart, amniocentesis, ultrasound, heart-lung machine, open-heart surgery, polio or measles vaccines, or coronary bypass surgery.

At the same time, less-expensive alternatives to hospitalization are being emphasized. American Hospital Association data show that outpatient surgery increased by 77 percent between 1979 and 1983, while inpatient surgery decreased by 7 percent. The American College of Surgeons reports that more than 300 surgicenters now exist, about half of them certified by Medicare. Physicians also are doing more procedures that were once done in the hospital in their offices or clinics. More diagnostic tests are being made on an outpatient basis, with the results given to the hospital when necessary, avoiding duplication.

Also, both the private and the public sectors are experimenting with new methods of financing and delivering care in more efficient and cost-effective ways. It is hard to tell at this point what will or will not work, what is or is not desirable. But I believe this Nation, as a Nation, will determine what is ultimately best for the health of the people, and then we will act accordingly. America's physicians will continue to give the real needs of their patients the highest priority. We believe that to be our foremost professional and ethical obligation. And we do not think the American people, our patients, would have it any other way.

blank page

Bernard R. Tresnowski

Bernard R. Tresnowski is President and Chief Executive Officer of the Blue Cross and Blue Shield Association, the national coordinating organization for the nationwide system of Blue Cross and Blue Shield Plans, a position he has held since 1981. A graduate of the University of Michigan, with a Master's Degree in Public Health and Hospital Administration, he joined the Blue Cross Association in 1967 as head of the Medicare Division.

Impact on beneficiaries

The Medicare-Medicaid partnership of government and the private sector has endured for 20 years, with everlasting benefit for the millions of American men, women, and children who have received care as Medicare and Medicaid beneficiaries. They have also been relieved of the major part of the burden of expense for illness and injury and spared the anxiety that is so often the accessory of illness, especially for elderly people with limited resources. The 20-year partnership is thus a success in the eyes of the American people.

On the 20th anniversary of the historic Social Security Amendments of 1965, it seems appropriate for those of us in the Blue Cross and Blue Shield organization to take a moment to recall what it was like as we crossed that threshold into public service. It is no secret that some among us had misgivings, from physicians who feared that the practice of medicine would never be the same to hospital executives who envisioned aged and penniless hordes streaming into hospital corridors, crowding out the ill and orderly patients who paid their own bills.

A year later, with 5 million Medicare patients cared for and paid for and doctors' bills paid for another 20 million, it was possible to take a calmer look. "Nobody can say just what services these millions of people would have had if we had not had Medicare and Medicaid," said a commentator at the time, "but it seems reasonable to suggest that some of them may have had no care at all, and many of them would have been cared for at considerable sacrifice or hardship to themselves and their families, and many would have had care as public patients without the freedom of choice of doctor and hospital they enjoyed as Medicare and Medicaid beneficiaries. All this has been accomplished without replacing or dangerously invading the voluntary health service establishment, but by using it and supporting it." (Cunningham, 1968)

The comment seemed apposite at the time, and it seems equally so 19 years and so many millions of patients later. It is still possible to assert, without reservation, that Medicare works, although not many would say the same of Medicaid. Because of the differences in goals and jurisdictions, however, the two programs obviously cannot be judged by the same standard. For all its shortfalls and its failure to "bring the poor into the mainstream of medicine," as sponsors of the legislation had expected it would do, Medicaid has nevertheless made strides toward that brave goal.

Despite problems, Medicare and Medicaid must be scored as a triumph of government for the people, if one considers that respect for the essential dignity and worth of the individual is a characteristic of democratic government. The magnitude of this respect is suggested by the 45 million hospital claims and 200 million professional service claims processed by Blue Cross and Blue Shield Plans, and the $48 billion paid under social security for the most recent Medicare year.

These are massive benefits bestowed on a substantial portion of the population by the people's Government, but this is not to say, of course, that the beneficiaries are uniformly grateful for the beneficence. It is commonly viewed instead as a right, and those who receive Medicare service are as likely as not to criticize. Illness is seen as misfortune; the instinctive reaction is resentment. The Good Samaritan got no praise from the wounded traveler. For Medicare, both Government, as payer, and Blue Cross and Blue Shield, as intermediary, have engaged in extensive and continuing education aimed at making certain that beneficiaries will understand their entitlements and know what part they must pay for themselves and why. But inevitably, the expectation exceeds the reality; the messages are not read or not understood, and there are disappointments.

An estimated three-fifths of all Medicare beneficiaries have private Medigap insurance covering the patient's share of hospital and medical expense. But, understandably, those with private supplementary insurance are those who can afford to pay for private supplementary insurance and those who can least afford to pay are without it. So dissatisfaction and misunderstanding continue, and, if anything, the incidence of disappointment has increased in recent years as budgetary constraints have dictated increases in the share of premium cost paid by beneficiaries for Part B (professional services) Medicare coverage. And for the least fortunate, those for whom repeated or prolonged hospitalized illness may become a drain on resources or assets, recourse to Medicaid may be unavoidable.

Critical as the hardships may be for those who must endure them until they can be eased or eliminated, they are minuscule alongside the monumental contribution Medicare and Medicaid have made, and continue to make, to the welfare and well-being of the aged and the poor. In short, the programs are doing the jobs for which they were created.

Impact on health care providers

Because the Blue Cross and Blue Shield organization has specific assigned responsibilities in the operation of Medicare and no comparable broad-scale functions in Medicaid, I focus largely on our part in the 20-year Medicare experience. It was not by accident that we became involved in what is a unique shared responsibility of Government and the private sector. As early as 1962, the Blue Cross Association (then still separate from the Blue Shield Association; the two were not merged until some years later) and the American Hospital Association (AHA) both had recognized that the problem of care for the aged would continue to grow along with the growing aged population, then already more than 15 million. We recognized that the need for assistance to this vulnerable group was already exceeding the abilities of State and local communities. Both organizations agreed that more Federal funds than were available under the Kerr-Mills Act, passed by the Congress in 1960, would be needed. In a joint statement that marked a sharp departure from earlier positions held by both groups, the associations' 1962 statement said that as long as the administration of the proposed Medicare plan remained in the voluntary prepayment system, the tax source of the funds would be considered of secondary importance. An earlier AHA statement had acknowledged that the use of social security to provide the mechanism to assist in the solution of the problem of financing these needs might be necessary ultimately.

As it turned out, ultimately was not that far away. Medicare and Medicaid were priority legislative objectives of the new Administration that took office following the 1964 election; passage of the Administration bill was a foregone conclusion, taken for granted, in fact, when AHA and State hospital association leaders met early in 1965 to talk over plans for making the program work. Social security would be paying the bills, and social security's representative at the meeting, Arthur E. Hess (who became the first director of the Bureau of Health Insurance and, later, Deputy Commissioner of the Social Security Administration), described what was meant by using and supporting the health service establishment, a concept that included, in his words, "professional leadership and the partnership of government and voluntary efforts." Every effort would be made, he assured the group, to arrive at policies, formulas, and methods that could be carried out at the local level, "by organizations that are already in the business of ascertaining costs for third-party reimbursement." (Cunningham, 1968)

The bill would permit any group of hospitals or other providers to designate a private organization to serve as a fiscal intermediary for carrying out reimbursement activities, Hess explained. The intermediary would receive and review bills from hospitals and other providers to determine the amounts of payment due, and make payment; the intermediary, later to be designated as "carrier" in the case of physician payments, would receive advances of funds from the social security program and be responsible for their prompt, proper, and efficient disbursement, accounting, in turn, to the Federal program.

Obviously, there would have to be boundaries on hospital and intermediary autonomy, and there were. "Of course, the Social Security Administration would still have the overall responsibility for sound administration of the program and would have to retain authority for final administrative decisions," Mr. Hess warned. As it turned out, there have not been that many changes in the ground rules over the years, though there have been repeated changes and improvements of procedures, methods, and practices. But the concept of Government as payer and the "voluntary establishment" as payment vehicle remains. This relationship has not been without strain. The partners at times have disagreed about tasks to be performed, methods to be pursued, and goals to be sought, but when the focus is enlarged to comprehend the achievement in terms of suffering eased, minds put at rest, and families made whole, strains and disagreements fade.

When the programs were initiated, the then Under Secretary of the Department of Health, Education, and Welfare, Wilbur J. Cohen, who later became Secretary, was seen as having formulated what journalists referred to as a "three-layered cake," with Medicare Part A (hospital insurance) as its base, Medicare Part B (professional services insurance portion) added next, and the cake topped off by Medicaid, which had comparatively little public discussion until it appeared as Title XIX of the proposed legislation. In contrast, the hospital and medical insurance benefit, Title XVIII, had been debated and reported at length and was well known to anybody who could read a headline. As Secretary Cohen explained to professional groups that were nervous about how the legislation would affect their status and their practice, the program was complicated and difficult to administer, "but if you want a simple law, the only place you can get it is in a totalitarian country." (Cunningham, 1968)

It was not an especially reassuring message, particularly not to doctors, who were far from convinced by the language of the law. It stated that there would be no Federal supervision or control over the practice of medicine or the administration of any institution, agency, or person providing health services, and there would be free choice of institution and physician by any patient entitled to benefits. "We shall adhere scrupulously to this congressional intent," the Secretary said. But doctors did not really believe it (Cunningham, 1968).

Today, every provider in the country is absolutely certain of one thing that the Secretary said: It is not a simple law.

Although there is no reason to believe anything other than that the Secretary and the Congress were both sincere in stating there would be no control over the practice of medicine or any institution or person, there is no question, either, that the effect on institutions and people has been, to put it succinctly, conform or forget it.

The fact that providers, with only a few exceptions, have chosen to put their shoulders to the wheel has been partly because, from the beginning, they have had their backs to the wall. Since shortly after the program began, hospitals and doctors have known they were dependent on Medicare. Although the numbers of beneficiaries varied according to the location of the hospital and characteristics of the population, generally, they exceeded expectations and were growing. Payment was based on cost, and these were not low-cost patients. Few hospitals could then, or can now, get along without Medicare. And depending on the nature of their practice, doctors to some degree faced the same situation. There was no compulsion, no supervision, as promised. But there was also no choice.

There was no warfare, either, and considering the pressure on providers to get paid enough and the pressure on Government to save money, the absence of warfare is a tribute to the wisdom of the intermediary principle. In view of the intensity with which both providers and payers necessarily approached considerations of cost during the 17 years payment was on a cost basis, the principle must have been right and the performance must have been equitable. And now that payment is moving to a fixed-price basis, the pressure on providers is increasing, if anything; fairness is critical, and the confidence in the intermediary system that has been generated over the years is working well in the switchover, although strain is never absent.

Certainly, any analysis of what has been taking place must include the influence of employers as purchasers of health care, through their contribution to employee health insurance, along with Government, in bringing about the reconfiguration of the marketplace. The fundamental change has been a reversal of the movement, which began in the late 19th century, of medical services out of patients' homes and doctors' offices and into hospitals, following the lead of specialization and technology. This trend continued until the reversal was touched off by the buyers' rebellion against high prices. Now medical services are moving out of hospitals and going back to where the people are, in neighborhoods where urgicenters, surgicenters, outpatient clinics, group practices, and other innovative medical delivery approaches are locating.

Impelled by the new forces now at work, physicians and patients are finding that many diagnostic and treatment procedures that have always routinely called for hospitalization can be performed safely and effectively in outpatient facilities and offices, including an astonishing range of surgical procedures. Medicare's fixed-price per case based on diagnosis has been, without any question, a chief impelling force. However, major employers, paying $600 a car and $20 a ton of steel for health care, also have joined the demand for change, and they are getting it. As the chairman of a Fortune 500 diversified manufacturing corporation described it, what is going on is "permanent structural change in the American health care system." (*Hospitals*, 1984)

At the same time, other cost-containment efforts are increasing in intensity as the pressures on cost have been rising. Deductibles and coinsurance or cost sharing are now the rule rather than the exception in employer contracts. Other methods in common practice among Blue Cross and Blue Shield Plans and insurance companies include preadmission certification and preadmission testing, second surgical opinion requirements, concurrent review, medical necessity requirements, discharge planning, and new benefits encouraging use of outpatient facilities and nursing homes instead of hospitalization. With all these safeguards in place, it is no longer possible for patients to tell their physicians, "Whatever you say. It is all paid for!" Instead, they are more likely to ask, "How much will it cost, and how much of that can we save?"

Impact on government

In an analysis a few years ago, at a time when changes in the intermediary contracting arrangements had been proposed, the Government's General Accounting Office (GAO) studied the existing contract performance and a proposed alternative arrangement and concluded that the existing contract with the Blue Cross and Blue Shield Association and individual intermediaries should be continued. The GAO referred specifically to the importance of the following: the interface of local subcontract intermediaries and providers; the efficiencies of the prime contract operations of the national telecommunications and data processing systems; and the many administrative tools and procedures for accounting, data processing, management, utilization review, cost containment, and other applications. For all these reasons, and for the important protection of the "special way of franchising," as the existing intermediary arrangement has been called, it would appear to be prudent to continue the arrangement at a time when the health care system itself is in the process of adjusting to the many new forms of delivery and financing that are emerging.

Although there have been and continue to be problems in the operation of Medicare, these problems are dealt with and either resolved or relieved over time. But these problems must be viewed in relation to the overall accomplishment of the program. Considering the millions of complex transactions handled every month, Medicare is an extraordinary administrative achievement. The only serious problem with Medicare has been its cost, which has exceeded estimates to an extent that at times has appeared to threaten the stability and adequacy of the Medicare trust funds.

Troublesome elements of the payment system have been recognized almost from the beginning of the program; the first national conference on medical costs, with Medicare costs as its principal focus, was convened by the Secretary of the Department of Health, Education, and Welfare John Gardner at the request of President Lyndon B. Johnson in the summer of 1967, when the program was barely a year old. The problem then was basically the same thing as it has been ever since. As the conference summarizer said, "Unlike scientific medicine, organization of health services is a field that more than most others has been dedicated unflinchingly to the rediscovery of the wheel. Many of the concepts that have been discussed here such as incentives, productivity, group practice, community health systems, and utilization controls—these and other organizational and procedural goals have been lying around in plain view, some of them for 20 years or more, now and again being re-invented, and re-explained, and re-exclaimed over, as succeeding generations of physicians, administrators, economists, social scientists, and journalists have entered or turned their attention to the health field." (Cunningham, 1968)

Two methods of control that were overlooked in the summary were payment method and competition. Both were discussed during conference sessions; provider payment methods were examined in detail, but prospective payment and prospectively approved budgets were not particularly emphasized, and competition among providers was mentioned chiefly to express regret for its absence. Health care enterprise in the 1960's was still firmly ruled by, or under the spell of, the doctor's concept of right and wrong behavior. Competing for patients was not ruled out, but talking about it was, and advocating it was unthinkable. With profit-making chains on the horizon and advancing, hospitals were beginning to shake off the spell, but aggressive marketing and advertising services were still more than a decade away.

After several years of controlled tests, Government implemented the prospective payment system (PPS) for Medicare. This has been one of the leading causes of the first real turnaround in hospital costs, not just since Medicare was introduced but actually since World War II, when hospital utilization dropped because one-third of the Nation's doctors had gone to war. Although there is no direct linking of PPS and the rise of competition, the fact that they have come on together has made both of them, unquestionably, more effective. The combination of PPS and competition, too, has helped to make price a foremost measure of value in the market for medical services, instead of a negligible, if not unmentionable, consideration.

The combined efforts of Government, employers, insurers, and patients themselves are taking effect for the first time since the early 1970's, when rigid wage and price controls were imposed and costs flattened out for as long as the controls lasted. Overall hospital expense was held close to the Consumer Price Index in 1984, and as the new market forces gather momentum, hospital admissions, lengths of stay, and occupancies are declining at an even sharper pace in 1985. Rates of decline vary by area, type of community, size and type of hospital, and local economy, but utilization as a whole is down by 5 percent in some cases and as much as 15 percent in others.

With so much changing so rapidly, there are bound to be disjunctions, dislocations, and resulting hardships. Some hospitals have been closed, and more unquestionably will have to close as the readjustment goes on. Up to now, most of those that have had to close have been small—50 beds or fewer—but the resulting hardship is no less severe for those whose lives are affected. Other hardships occur in cities where voluntary hospitals with depleted resources are compelled to turn away patients seeking care who are without insurance and without funds. Except in life-threatening emergencies, such patients in growing numbers are being referred instead to public hospitals, whose facilities and funds are already under stress and, in some cases, threatened with failure. In States where Medicaid budgets have been cut while Medicaid demands are increasing, corrective action may be needed to avert serious breakdowns.

Implications for the future

A problem that, although not widespread, is disquieting nevertheless is the possibility that the quality of care may be eroded by the pressures on hospitals, which devolve on physicians, to avoid admissions, hold down stays, and speed up discharges in order to keep costs within limits under diagnosis-related groups (DRG's). Ever since the system was first introduced in the New Jersey trials and, increasingly, since Medicare PPS became law, hospital people have been aware of the need for trustees, management, and medical staffs to develop specific procedures for safeguarding against excessive admissions, stays, and services. Figures just now becoming available suggest that the goal is being pursued; the journals are awash in articles describing the methods.

There has been less talk, and fewer articles, about the need for avoiding excesses of zeal, and one hears stories of coronary bypasses discharged on the fifth postoperative day, outpatient prostatectomies on 80 year olds, and patients suffering transient ischemic attack sent home with no neurological workups. This is not a problem for Medicare, or for intermediaries, employers, medical societies, or hospital associations. It is a problem for individual physicians and individual hospitals and their trustees, managements, and medical staffs, and it is a problem of conscience. Administrators may excuse excessive pressure to avoid loss at fixed prices by telling themselves, and their doctors, that "we can't help anybody unless we stay in business." But this dodges the real issue, which is that a hospital business is still a hospital, with a mission to treat the ill and injured and a special ethic that puts the mission ahead of the business when circumstance calls for choice. Without the special ethic there is no mission, and without the mission, what is the hospital there for?

Safeguarding the Medicare trust funds for the future has been a preoccupation of Government, providers, and interested segments of the population ever since the first questions about its security began to emerge several years ago. There has been no lack of suggestions. One proposed solution has been to meld the hospital insurance and supplementary medical insurance trust funds; this would permit greater flexibility and adjustments as needed, with access to general treasury funds. A voucher system with beneficiary choice of health maintenance organizations as opposed to traditional insured practice is now being tested; this approach is seen by many, in and out of Government, as promising the substantial savings that have been demonstrated in capitation plans. Others are convinced that consumer choice is an invitation to adverse selection and a sure road to disaster over time, pointing to the Federal Employees Health Benefits Program as an example. DRG's for physicians have been under study and may yet be tried.

For the long term, tax increases in one form or another may be inevitable, either separately or in combination with some kind of means test for beneficiaries and perhaps, also a system of adjusting benefits according to age as well as income. People over age 65 are neither as vulnerable nor as hard up as they were 20 years ago; they are robust and rich in comparison with their counterparts of the 1930's, when social security began and age 65 was seen as the end of living instead of the beginning of leisure. It may take another generation to get it done, but the means test, at any rate, is a certainty. Whatever else may be done, it no longer makes sense for the Medicare trust funds to be depleted to pay for pacemakers and bypasses so yachtsmen and golfers at Boca Raton and Hilton Head can enjoy the sun without calling the bank.

The future of Medicaid is something else. A sobering study 2 years ago by the Robert Wood Johnson Foundation (1983) counted 28 million Americans who had been without needed medical care during the year preceding the study. Since that time, both State and Federal budgets have been reduced and State Medicaid eligibility rules have been tightened, in some cases drastically. In fact, if there has been a time when any part of the health care system established by the Social Security Amendments of 1965 has been close to failure, the part is Medicaid and the time is now. One of the reasons is money. Up until 1983, at least, hospitals had become accustomed to accepting and treating whoever showed up at the door, confident and content that whatever was done would be paid for. There were always discounts, often steep ones, from actual costs, to be sure. But as long as there were beds, it was better for them to be full than empty; without doubt, some hospitals became relaxed, if not negligent, about investigating patient resources and pursuing patient payments.

Not much laxity is left in the system today. Any laxity remaining, when the unemployment of 1981 and 1982 began to recede, vanished as DRG's advanced and below-cost arrangements with local authorities could no longer be supported by above-cost payments by private and insured patients. With occupancies going down, there are empty beds all over, but not in public hospitals, where beds are filled with the sickest patients and others are sitting and standing in corridors and reception areas, waiting to be seen. Visitors to a Bellevue or Boston City or D.C. General or Metropolitan or Charity or Cook County hospital today can see the problem plainly as soon as they open the door. The problem is money; money would make it possible for the patients overloading public hospitals to get care where they got it before, in all the other hospitals that for years had been charging those who would be paid for or could pay themselves for those who could not pay.

There is little likelihood that we shall go back to the old way. It was uneven, illogical, unfair—a "tax on the sick." But unevenness is inherent in most of the solutions that are being proposed and tried out now—the new tax on hospital revenues in Florida, allocations of funds of one kind or another in New York and Massachusetts, a law in California that makes county institutions responsible for medically indigent adults. Most of the proposed solutions turn out to be taxes on the sick, at least indirectly. A tax on employers as payers for private health insurance has been suggested, and voluntary coalitions of business, providers, insurers, and local public health people have proposed local responses to community needs, although no notable success has been reported.

Also failing to evoke enthusiastic response is the one proposed solution that would eliminate the unevenness, if only to spread the hardship around equally from State to State, by federalizing Medicaid. Nobody has been willing to say more than that a federalized Medicaid would be the least objectionable method of seeking to make sure the unprotected are protected. There is now widespread recognition that the problem is already out of hand in many communities and growing. Remarking on the foundation report 2 years ago, of the 28 million uncared for, a respected health care economist predicted that if the number were to reach 40 million, the public outcry would become overpowering.

Action taken in crisis is not the ideal way to solve problems, but it is better than no action. So there will be action. There will be no failure of Medicaid that can diminish the success of Medicare, which must also expect and prepare for change in the future as it has done in the past. Some adjustments of eligibility requirements are inevitable to keep income in manageable proportion to outgo as the elderly population continues to grow at an accelerating rate. The forthright change in payment practice introduced in 1983 has already demonstrated its effectiveness in restraining utilization. What is needed now is continued adjustment to compensate imbalances and forestall injustices that may develop and, especially, to protect against impairment or erosion of the integrity and quality of institutional and professional services. The quality of the services and the success of the program over two decades have demonstrated that the special partnership of Government and the private sector works. It was needed for the program to get started, and it is needed as the program goes on.

References

Cunningham, R. M.: *The Third World of Medicine*. New York. McGraw-Hill, Inc., 1968.

Hospitals: Current health industry change seen as permanent. 58(12):24, June 16, 1984.

Robert Wood Johnson Foundation: *Updated Report on Access to Health Care for the American People*. Special Report, 1983.

Karen Williams

Karen Williams is the Director of Research and Policy Development for the Health Insurance Association of America, a national trade association representing 335 commercial insurance companies that underwrite private health insurance. She was previously with the Health Care Financing Administration, where she participated in development of the Medicare prospective payment system as well as managing budget and legislative proposals. She also has several years' experience in State and local programs for medical and social services.

Impact on beneficiaries

The achievements of Medicare and Medicaid are dramatic and should not be minimized. These programs have largely achieved their original purpose of assuring access to health care for the elderly and the poor. Although other major industrialized nations have similar accomplishments, only the United States has not resorted to nationalization of health care in order to achieve this goal. Instead, we have parallel public and private financing systems that utilize the same private delivery system.

As purchasers, many of the problems facing the public and private systems are similar. We are both seeking to cover only medically necessary care and to encourage cost-effectiveness in the health care delivery system. We are both wrestling with issues created by new technologies. But we have far more in common than just our problems. When Medicare and Medicaid were created, their coverage and payment systems were modeled after private insurance plans. In the 20 years since then, we have learned from one another's successes and failures.

In 1984, these programs together spent $97 billion in Federal and State funds to provide access to a wide range of quality services for 49 million people. Despite this level of effort, our Nation has fallen short of its original goal. Even more troublesome, we have many difficult choices ahead if we are to sustain our current degree of success.

The original goal of removing financial barriers to those who need care the most is not yet complete. At the end of 1982, between 10 and 15 million Americans were without public or private coverage. In 1983, Medicaid covered only 40 percent of those with incomes below the Federal poverty level. To the extent these people obtain access to care, providers incur costs that are often uncompensated. In 1983, such costs exceeded $7 billion to hospitals alone. In turn, hospitals shift such costs by increasing charges to private patients. These remaining gaps in entitlement thereby create a fearful hardship for the unprotected and a growing burden on the insured.

For those entitled to Medicare and Medicaid, the programs' success needs closer examination. The past 20 years has seen a slow increase in the number of Medicare eligibles (approximately 3 percent per year) and no sustained increase in the number of Medicaid recipients. Yet expenditures have increased annually at 18 percent for Medicare and 11 percent for Medicaid.

What has been responsible for these increases? Increased costs were not a result of reductions in beneficiary's personal liability. On the whole, the elderly now spend the same percentage of their income on health care as they did before Medicare was enacted. Nor was expansion of covered benefits responsible for increased outlays. Numerous States have reduced the scope of Medicaid benefits, including implementation of annual limits on hospital days and physician office visits. Although Medicare has avoided similar limitations, benefits for retirees have not kept pace with private sector coverage for either minor medical needs or catastrophic illness.

From the Medicare beneficiaries' viewpoint, there remain significant coverage gaps. These gaps include long-term care, outpatient drugs, eyeglasses, dental care, and hearing aids. Beneficiaries are also liable for any doctor's fee above the charge level recognized by Medicare. Some of these gaps may be covered through privately purchased Medicare supplemental insurance. Protection against a catastrophic illness, especially one requiring long-term care, is not provided by Medicare nor readily available in the private market.

An obstacle to the emergence of private insurance for long-term care is Medicaid eligibility loopholes. Through the use of certain tax devices, elderly persons with personal resources are able to obtain Medicaid benefits. Although the motivations of these elderly individuals are understandable, such tax devices divert limited resources away from other eligible low-income groups that include children and their families and the disabled. Many States have been forced to restrain Medicaid eligibility and benefits as the program's long-term care outlays continue to escalate. In 1980, elderly Medicaid patients represented only 16 percent of all Medicaid eligibles, yet consumed 37 percent of all Medicaid funds. This is even more disproportionate when you consider that nearly all elderly Medicaid patients are eligible for both programs and continue to receive payment for basic medical care under Medicare.

In summarizing past accomplishments, it is fair to say that the initial designs of Medicare and Medicaid greatly enhanced access to basic quality care. But, with the exception of increased Medicaid funding of long-term care, these programs have not used significant increases in funding to expand eligibility or coverage. Rather, expenditures by all purchasers, Government and private alike, have steadily risen to pay for more costly, more frequent, and more intensive treatments per patient. In response, the management focus for Medicare and Medicaid has been narrowed from access, quality, and adequate coverage to cost containment.

Far more difficult than financing current benefits for current Medicare beneficiaries will be retaining those benefits for future retirees. Enormous burdens are being placed on Medicare by increased longevity, decreased birth rates, and the rising cost of care. Over the next quarter-century, the number of retirees will expand rapidly in comparison to the workers who finance their Medicare benefits. This larger retired population will include more frail elderly who require extensive care. Meanwhile, the cost and volume of both acute and chronic treatment will continue to escalate.

As the population ages and the cost per beneficiary continues to rise, some areas of Medicare eligibility will come under additional scrutiny. First, the availability of identical Medicare benefits to all elderly, regardless of their financial resources, will face additional criticism, because, in general, the economic position of the elderly has improved in recent decades relative to the nonelderly population. Second, eligibility based solely on a disabling disease may well be viewed as a personal or private sector obligation. Given the aging of the population, the Medicare program is inadequately financed to provide care for a very small percentage of the population that accounts for a significant percentage of total funding. Thus, it is increasingly unlikely that new entitlements will be created by diagnosis, despite advancements in technology.

In addition to possible eligibility reductions, Medicare and Medicaid patients have reason to fear future reductions in access and quality. If payment levels to providers are steadily reduced under these programs, providers will increasingly favor treatment of private paying patients. So long as the Government legislates cost containment for its own programs, yet fails to address restraints on private payments, Medicare and Medicaid beneficiaries are at risk for second-class care.

Another payment reform initiative, capitation, may well pose the most difficult challenge facing Medicare and Medicaid patients. Under capitation, a provider agrees to deliver a certain range of services in exchange for a fixed dollar amount per beneficiary. The most comprehensive and well-known capitation model is the health maintenance organization. New models are emerging in response to initiatives by State Medicaid agencies, private insurers, and various health care providers. These models include preferred provider organizations, competitive medical plans, competitive bidding arrangements, and some prospective payment mechanisms.

Beneficiaries have three risks under capitation arrangements. First, access and quality of care are at risk whenever providers have financial incentives to provide as little care as possible. This is true even if the fixed payment per beneficiary is reasonable. So long as patients can choose between capitation and independent traditional fee-for-service practitioners, this risk is minimized. Second, proposals to increase capitation for Medicare beneficiaries, including the voluntary voucher proposal, risk adverse selection. Beneficiaries may elect capitated systems while they are healthy, but return to the basic program if their health deteriorates. Without an adjustment for health status, Medicare funding to capitated plans may therefore be too generous, while the costs for the noncapitated portion of the program may increase even more rapidly. Third, if the Government sets its price per capita below a reasonable level, providers will have a strong incentive to reduce benefits, access, or quality.

Finally, the beneficiaries of the Medicare and Medicaid programs will face increased pressure to become more aggressive consumers of health care. Similar expectations are now being placed on the working public by private insurers and employers. As all payers struggle to better manage health care costs and utilization, patients will be asked to make more sophisticated choices between providers and to experiment with limited freedom of choice. It remains to be seen whether many of us, as individual patients, can adequately fulfill such expectations.

Impact of health care providers

Government financing of health care was in many ways a dream come true for providers. The structure of both programs enabled providers to generate demand for their services and to receive payment for their services regardless of the cost. Health care providers had such latitude because of cost-based reimbursement and weak coverage controls initially adopted by Medicare and Medicaid. But Congress and most State legislatures have found the resulting costs to be unsupportable. Only the future will show whether recent cost-containment efforts have found a better balance between the interests of beneficiaries and those of providers.

The designers of these programs had cost containment in mind at the onset. Their choice of cost-based reimbursement had certain advantages over payments of charges, the only other alternative in use at the time. Charge-based payers, such as commercial insurers and nearly half of all Blue Cross plans, pay their share of all the costs of operating a hospital. A hospital's financial requirements include costs directly related to patient care as well as bad debt, charity care, working capital, and operating margins. In establishing cost-based reimbursement, Medicare selected those hospital costs that it would recognize as related to the treatment of Medicare patients. Such costs as charity care and non-Medicare bad debt were not included. Since most States initially adopted Medicare's payment rules for Medicaid, hospitals have been forced to recover charity and bad debt costs disproportionately from private payers.

Nonetheless, cost-based reimbursement proved to be unacceptably expensive. Providers could not increase their margins except by reporting cost and volume increases. Productivity gains by the hospital actually reduced Government revenues. As a result, an incentive was created for the use of expensive new technologies and services. A disincentive was simultaneously created for cost-conscious care.

The Government first attempted to regain control over provider expenditures by the placement of "reasonable upper limits" on those costs that were recognized for payment. Beginning in 1974, Medicare compared the costs of inpatient routine per diems and disallowed costs too far above those typical for similar hospitals. In response, many hospitals effectively claimed increased ancillary services and costs for their Medicare patients. As a result, only a tiny percentage of Medicare funds were actually saved by these limits.

Medicare has experienced a similar lack of control over covered services. Providers have needed little more than a physician's signature to dramatically expand the range and volume of care provided to beneficiaries. Once the medical community has endorsed the safety and efficacy of a new procedure, it soon becomes readily available for use. On the other hand, the cost effectiveness of new treatments and individual patient need are difficult to measure and even more difficult to enforce. Medicare has recently taken more serious steps to discourage unnecessary utilization. Medicare's newly established peer review organizations, for example, will increase efforts to reduce unnecessary admissions.

Medicare's utilization problems are similar to those driving up private sector costs. Our solutions have a somewhat different focus because we have neither data nor authority similar to Medicare's. Without a community-wide data base, it is difficult to identify treatment norms and abusive practioners. Without the force of law, it is often impossible to obtain provider cooperation in utilization review and control. Therefore, private payers are increasingly emphasizing patient use of second opinions and preadmission review, as well as selection of physicians who practice conservatively. Despite their effectiveness to date, current utilization controls will become inadequate as advancement in medical technology continues. Complex financial, social, ethical, and medical issues with intensify. We hope private and public payers will pool their resources and work with the medical community to more effectively address these issues.

Medicaid began operation with similar blank checks to physicians and providers. But as soon as Federal law allowed more flexibility, States tightened their control on both reimbursement and utilization. Innovative Medicaid reimbursement reforms include physician fee schedules, competitive bidding for Medicaid services, and hospital prospective payment systems. States also continue to aggressively experiment with utilization controls including preadmission authorization, waiver of freedom of choice, enrollment in alternative delivery systems, and limits on the amount and duration of provider visits. Admittedly, the results have been mixed. On the positive side, statewide all-payer systems have saved money for Government programs and private payers alike while stabilizing the financing of charity care and medical education. On the negative side, underpayment of providers has led to early abuses such as Medicaid mills and unscrupulous health maintenance organizations for the poor. Current Medicaid underpayment to hospitals in some States encourages cost shifting to private patients who are not protected by State cost controls.

Providers have prospered continuously since Medicare and Medicaid were created, despite numerous attempts to slow their growth. From 1976 to 1982, hospital revenues have increased by 162 percent and, despite excess capacity, the number of hospital beds increased by another 13 percent. From 1978 to 1983, the salaries of hospital workers increased by 60 percent. Between 1976 and 1983, hospital margins (the difference between revenues and costs) increased steadily from 2 to 4 percent, despite fluctuations in the general economy. Hospital occupancy has declined dramatically because of recent changes in private and public benefit designs. Although hospitals have decreased their staff size somewhat, the ratio of employees to patients still increased between 1982 and 1983, as did hospital workers' wages. It is therefore questionable whether hospital productivity gains are keeping pace with recent utilization controls and payment reforms by public and private payers.

Hospitals have prospered so well for so long because most controls that were enacted were relatively ineffective. Medicare's limits on inpatient routine per diem rates were largely avoided by increasing inpatient ancillary costs or by shifting unreimbursed Medicare costs to private charges. The effectiveness of Medicare's new prospective payment system, which fixes the full payment by diagnosis, may be reduced by increased delivery of Medicare services pre- and post-discharge. Likewise, any Medicare costs not actually recovered can still be shifted to private charges. In contrast, statewide payment reforms have demonstrated that cost controls and productivity incentives can be effective when applied to all payers for a comprehensive set of services.

The battle by all payers to rationalize their health care expenditures will continue for the forseeable future. For their part, Medicare and many Medicaid programs seem intent on offsetting any growth in eligibles and services by further reductions in payments to providers. Government reliance on the private sector to absorb additional cost shifting may prove faulty because of more statewide regulation and increased competition. Several more States have enacted legislation for all-payer systems that would guard against cost shifting. Increased data capability is encouraging price and utilization comparisons among providers. Employees are increasingly rewarded for selecting less expensive providers.

Although these initiatives may encourage some competition, it is critical to note that the providers with the least charity care, the fewest Medicare and

Medicaid patients, and no medical education costs can offer lower prices to the private sector. These providers and private payers who continue to bear the costs of such services are being placed at a competitive disadvantage that cannot be sustained indefinitely. If the cross-subsidies for the poor and the elderly continue to erode, problems with quality and access will re-emerge.

Impact on government

Pay-as-you-go financing has proven inadequate for Medicare and Medicaid. Yet most financing reforms seek to shift, rather than reduce, program liability. A more responsible way to reduce program liability is to expand experimentation with State and Federal program design. Research and demonstrations, coupled with independent evaluation of their results, have paved the way for more effective program reforms. By getting more health care benefit per dollar, we may avoid depletion of funds, rationing of benefits, and a greater burden on workers and those with limited resources.

One of the key decisions that affected Government expenditures for Medicare and Medicaid was the concept of current financing. The funding of health care on this pay-as-you-go basis has been an insurance tradition and we find it generally acceptable. Under Medicare and Medicaid, the burden of financing health care for the elderly and the poor is thereby spread across all workers. However, the Government's use of current financing has suffered from two erroneous assumptions. First, the shift toward an older population with a corresponding decline in the ratio of workers to retirees was not adequately anticipated. Second, increases in the cost of health care have exceeded increases in workers' wages. Because of these two factors combined, outlays have outpaced revenues.

Federal and State contributions to Medicaid were rendered less predictable because of frequent changes in the design of the Medicaid program. Since Medicaid's inception, each State has had considerable latitude in eligibility and coverage and, more recently, in reimbursement policy. Over the years, congressional mandates have alternated between specific eligibility and coverage expansions, overall expenditure reductions, and widespread eligibility contractions. The cycle is now turning to mandated eligibility, coverage expansions, and renewed debate on overall expenditure caps.

The Medicare financing solutions most frequently discussed do little to reduce program liabilities or inequities. Most proposals merely increase or shift program liability to non-Government entities. Before resorting to increased payroll taxes or means-testing of retirees' benefits, Medicare should further reform the payment system. Our first line of defense against Medicare bankruptcy should be to pay out less from the Medicare trust funds rather than to expect workers and elders to simply pay more into it.

A recurring proposal for Medicaid financing is to cap Federal contributions at some historical level. This proposal has substantive defects. It ignores the fact that any decline in a State's economy will simultaneously increase the number of poor people eligible for Medicaid and decrease the State's ability to care for them. To maximize the cost effectiveness of Medicaid funds, the States need greater program flexibility and the time and Federal encouragement to use it.

A major advantage of State administration of Medicaid has been the opportunity for experimentation with program design. State fiscal constraints combined with local ingenuity have resulted in the New Jersey diagnosis-related groups system, channeling experiments for long-term care, social health maintenance organizations, competitive bidding for a range of services, and primary care case-management systems.

With respect to the strengths and weaknesses of federally-administered versus State-administered programs, payers should have the right to control expenditures for which they are responsible. That right clearly would argue against Federal administration of Medicaid so long as States have significant financial obligations under the program.

The uniform administration of Medicare has resulted in a high level of efficiency. The Medicare program has been a successful, cooperative effort, jointly administered by the Federal government and private companies on a contractual basis of no profit, no loss. Since Medicare's inception, nine of our national carriers have contracted with the Federal Government to provide prompt services to beneficiaries and providers at the lowest possible cost. The quality of service has been high and the administrative costs to Medicare are now less than 1 percent of total outlays, a truly remarkable record.

Despite its quality and consistent cost effectiveness, Medicare's uniform system of administration has two significant shortcomings. First, there is insufficient linkage between Parts A and B to permit a comprehensive analysis of cost and utilization data. Such analysis would facilitate development of additional utilization controls and payment alternatives. Second, Medicare's long-standing partnership with private carriers may be jeopardized by imprudent budget cuts. Proposals to reduce contractor budgets ignore both workload and cost increases. Experience has shown that such reductions are likely to delay payments to beneficiaries and increase program overpayments to providers.

Regarding competition versus regulation, the greatest cost-effectiveness will come from a balance of these strategies. In a sense, Medicare combined competition and regulation when creating its new prospective payment system. First, Medicare calculated a fair market price for hospital services using actual program data. Then this price was enforced through regulation. This in turn forced hospitals to compete based on their productivity. A similar use of regulation to foster competition has been undertaken in several States where Medicaid now uses some form of prospective payment.

Unfortunately, regulatory authority can become protective or destructive, if it is abused. Regulation becomes too protective if, in a State rate-setting program, hospitals are guaranteed solvency without regard for their efficiency or for community need. We believe it is also an abuse of regulatory power to set prices below a fair market value. This will occur if diagnosis-related group prices are frozen without a reasonable adjustment for inflation.

Competition, just like regulation, can result in greater general good or in harm to the public. For example, the widespread availability of meaningful price data is the key to any competitive industry. But unfettered price competition would erode and eventually destroy current financing for indigent care and for medical education. Expensive, low-volume services such as neonatal, burn, and cardiac care could also become scarce.

The primary weakness in both the Medicare and Medicaid programs is the failure to recognize that the same health care delivery system provides services to both private and public patients. Public and private financing and expenditure levels are fundamentally interrelated. If Government, as the predominant payer, infuses the system with unlimited capital, all other patients pay for capital expansions. Conversely, if Government relentlessly reduces revenues, someone will suffer. Either private patients will pay more, or Government patients will not be treated as well, if they are treated at all. If competition is to mean more than simply maximizing profit, if it is to mean getting the most health benefit for every patient's dollar, then competition has to be fair. A level playing field has to be established so that all payers and providers can compete on an equitable basis.

Implications for the future

Medicaid will face three basic issues in the future. First, who will be responsible for those poor people whose care is currently financed by hospitals through cost shifting to the private sector? Second, how can access to mainstream quality health care be retained despite reduced payment levels and limited freedom of choice? Third, given the increased need for long-term care and the opportunity for Medicaid eligibility, how can private financing options for the nonpoor elderly be encouraged?

There are Medicaid program design problems that also need resolution. First, more frequent manipulation of Medicaid eligibility rules will increase the need for alternative sources of long-term care for the nonpoor elderly. Second, the annual financing crisis may also force Government officials to reconcile competing political pressures to fund transplants for a handful of children while thousands more have inadequate access to basic medical care.

The fundamental question for Medicare's future is how to maintain the scope and quality of current benefits despite the growth in the elderly population. To resolve these problems without substantial additional financing will require both programs to achieve greater cost effectiveness in medical treatment and to implement additional payment reforms.

Several treatment issues must be addressed by all payers. Substantial and inexplicable variations in admission rates and in the use of common diagnostic and treatment procedures must be confronted. Just as data collection and analysis revealed unacceptable variations in cost, similar work must be completed with regard to utilization. Better measures of outcome for medical treatments must also be developed if both resources and health are to be maximized. Establishment of criteria for appropriate use is especially important as expensive new technologies continue to outpace our ability to make ethical, moral, political, or financial decisions concerning their dispersion. Furthermore, if fears of abuse arise under public or private prospective payment systems, providers will be called on to demonstrate adequate levels of quality in order to retain public confidence.

Payment reforms must continue so that providers become more conscious, not simply of cost or profit, but of cost benefit to the patient. Work should therefore be completed on physician payment reforms. Current payments to physicians appear to favor new physicians just establishing their practices, as well as new specialities and new treatments. Reform is also needed to rationalize financing of graduate medical education, the distribution of physicians, and incentives in the practice of cost-effective medicine. Additional bundling of services into prospective payment systems should be undertaken to reward cost consciousness by all providers. Finally, additional capitation models should be explored so that quality becomes a major concern for patient and practitioner alike.

After much success, Medicare and Medicaid still have a job that is incomplete and problems that threaten to undo past accomplishments. Although there are no obvious and palatable answers, past experience indicates a path toward workable solutions.

Medicare and Medicaid need continued program flexibility and experimentation. Without that flexibility, the rising cost crisis will recreate the access and quality problems these programs were intended to solve. Such experimentation must result in better payment incentives and new safeguards for quality. These must be accompanied by a new focus on health promotion and patient education, along with a further de-emphasis of acute and high-technology delivery settings. And, if all patients are to benefit from emerging competition in health care, there must be regulatory oversight to assure consistent rewards for all cost-effective providers and purchasers.

Medicare and Medicaid have indeed come to a crossroads. Despite a projected delay in Medicare bankruptcy and surpluses in a few States, we cannot afford to allow time to pass without reassessment and revisions. If we do not address the fundamental incentives in these programs now, we will later have only simplistic and harsh alternatives such as benefit

cuts, payment reductions, and increased taxes. Genuine reform requires more time, thought, and initiative, but it is in the best interest of these programs and the people they were designed to serve.

MAR 1 [illegible]

*U.S. GOVERNMENT PRINTING OFFICE: 1985-493-952

A message to our readers:

This issue of the *Health Care Financing Review* presents an intriguing format: an accounting of the legislative history of the Medicare and Medicaid programs by the real-world participants; an overview of 20 years of program data; and a Symposium of ideas and opinions from scholars and policymakers on a set of questions about the impact of the Medicare and Medicaid programs after 20 years, as well as the issues they face in the future. The fact that so many distinguished persons accepted the Health Care Financing Administration's invitation to take part in this evaluation attests to the vital importance of these programs and to the major role they play in the Nation's health care system.

The historical account captures the complexities and fortuitous aspects of American politics. The overview article highlights the salient facts about the experience of the Medicare and Medicaid programs' beneficiaries and their use and costs of services. The Symposium responses deal with that experience during two decades of extraordinary change, particularly in the growth of knowledge about the impact of large-scale health care financing systems.

The combined viewpoints of the Symposium contributors provides a unique opportunity to reflect on the knowledge and range of perspectives of leaders from the Nation's major institutions that shape our health care financing and delivery system. We are deeply indebted to them for their contributions to this forum; their responses represent a compelling and worthwhile exchange of ideas on issues that affect so many of our Nation's citizens.

We are also indebted to you, our readers, for your continued interest in and support of our journal. We hope you find this special issue to be an important source document on the Medicare and Medicaid programs in the years ahead.

Gerri Michael-Dyer
Managing Editor

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
OFFICE OF RESEARCH AND DEMONSTRATIONS
6325 SECURITY BLVD.
BALTIMORE, MARYLAND 21207

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE. $300

POSTAGE AND FEES PAID
U.S. DEPARTMENT OF H.H.S.
HHS-392

SPECIAL FOURTH-CLASS RATE

U.S.MAIL

MEDICARE
MEDICAID 20th

U.S. Department of Health and Human Services
Health Care Financing Administration
Office of Research and Demonstrations
HCFA Pub. No. 03217 December 1985